

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

18788

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 18 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6			
d. NAME OF HOSPITAL OR (INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 3617 Glenmore Avenue			
3. NAME OF DECEASED (Type or print) ROBERT F. ALLERS (Served ROBERT F. ALLES)				4. DATE OF DEATH Month August Day 23 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1894		9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Refrigerators		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME Henry Allers				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 215-05-4937			
17. INFORMATION Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALOMALACIA, LEFT CEREBRAL HEMISPHERE DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL FIBROSIS DUE TO CORONARY AND GENERALIZED ARTERIOSCLEROSIS Terminal (c) ULCERATED RT. ANKLE DUE TO THROMBOSIS, AORTA Portion RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TERMINAL BRONCHOPNEUMONIA -				INTERVAL BETWEEN ONSET AND DEATH 3 YEARS UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X (this hospital) attended the deceased from August 5, 1961 to August 23, 1961 that (X (we) last saw the deceased alive on August 23, 1961 , and that death occurred at A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Sebastian Russo</i> M.D.				22b. DATE SIGNED 8/23/61			
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-25-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24b. ADDRESS 6009 Harford Rd., Balto. 14, Md.		25a. REC'D BY REGISTRAR AUG 28 '61			
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

Indication

Port Number

10 Days

Ballistics

Ballistics

Veterans Administration Hospital

3000 Glenwood Avenue

IDENTITY
(Typed Name)

Y.
P.
P.
(Typed Name)

August

Date

June 2, 1954

67

Telephone Number

Investigator

Ballistics, Maryland

County, State

Local Name

Criminal Records V.E. Baltimore 14, Maryland

Port Social Division

100-100-100

W. I.

For

EXHIBIT, LEFT CENSUS NUMBER

UNIVERSAL ALPHABETIC

NUMERICAL INDEX

COPIES AND SERIALS ALPHABETIC

RECORDED IN ORDER TO NUMBER, SERIAL, INDEX

THIRTY-THREE

August 2, 1954

August 11, 1954

Handwritten signature

RECEIVED, N.D.

Baltimore National Cancer Hospital

100-100-100, Jan. 1954, N.D.

CERTIFICATE OF DEATH

Reg. Dist. No.

98789

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home.</u>		d. STREET ADDRESS <u>1120 W. Pratt St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type as printed) First <u>CALVERT</u> Middle <u>ARRINGDALE.</u> Last <u>—</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1961.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Guard Serv. Balto., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Arringdale</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Dorritee.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Ferdinand J. Doyle</u>		Address <u>3416 Ellioitt St. Balto., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegic left old</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/15/61</u> to <u>8/15/61</u> , that I last saw the deceased alive on <u>8/15/61</u> and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1303 Frederick Rd. Catonsville, Md.</u> DATE SIGNED <u>8/15/61</u>			
ACTUAL SIGNATURE <u>W. E. McGloth</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGloth</u>		<u>Catonsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-18-61.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>5712 O'Donnell St. Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeller</u>		ADDRESS <u>901 S. Conkling St. Balto., Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL BANK OF INDIA

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8797

08790

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3yr4mth26dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland d. STREET ADDRESS Beacon Light Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles B Ashton			4. DATE OF DEATH Month August Day 18 Year 19 61				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1887		9. AGE (In years last birthday) 73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) transit operator		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George Ashton			14. MOTHER'S MAIDEN NAME Emily				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 18, 1958 , to Aug. 18, 1961 , that (I) (we) last saw the deceased alive on Aug. 18, 1961 , and that death occurred at 8:14 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachler		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Stella Wachler M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		22b. DATE SIGNED 8-18-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 19, 1961	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City, town or county) Colmar Manor, Md. (State)				
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons ADDRESS Hyattsville M.			25a. REC'D BY REGISTRAR AUG 21 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Krays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the 4 may be retained by the hospital or attending physician, this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the attending physician. After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8798

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08791

Items 4 & 8 Film 8293 8/31/61 10K

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b X Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7043 Concord Road		d. STREET ADDRESS 7043 Concord Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle ATTMAN Last Last		4. DATE OF DEATH Month August Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1901
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Yechel Shapiro		14. MOTHER'S MAIDEN NAME Rachel ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Harry Attman- 7043 Concord Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1961 , to Aug 24, 1961 , that (I) (we) lost the deceased alive on Aug 23, 1961 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Albert J. Himelfarb		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALBERT J. HIMELFARB		22d. ADDRESS 3501 ST. Paul ST. - Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 24/61	
23c. NAME OF CEMETERY OR CREMATORY Shomre Mishmeres		23d. LOCATION (City, town, or county) (State) Rosedale, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc.		25a. REC'D BY REGISTRAR AUG 28 '61	
ADDRESS 6010 Reist Road		25b. REGISTRAR'S SIGNATURE William L. Hume	

3735

(M)

(1)

Page

THE HISTORY OF THE

ALBERT HERRING

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8799

CERTIFICATE OF DEATH

08792

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 8yr5mth21dys c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 VOI-4 d. STREET ADDRESS <u>914 Whitelock Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Betti</u> Middle 5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY Germany		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>unknown Moses Spuer</u>		14. MOTHER'S MAIDEN NAME <u>unknown Helena</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) _____ (County) _____ (State) _____			
21. I certify that (If this hospital) attended the deceased from <u>Feb. 10, 1963</u> to <u>Aug. 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 1, 1961</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 8-1-61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 E. 1st Ave</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 3 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician, if the death occurs in the hospital or is attended by the physician, must sign the certificate. The law also requires that the funeral director, if the death occurs outside the hospital, must sign the certificate. The law also requires that the funeral director, if the death occurs outside the hospital, must sign the certificate. The law also requires that the funeral director, if the death occurs outside the hospital, must sign the certificate.

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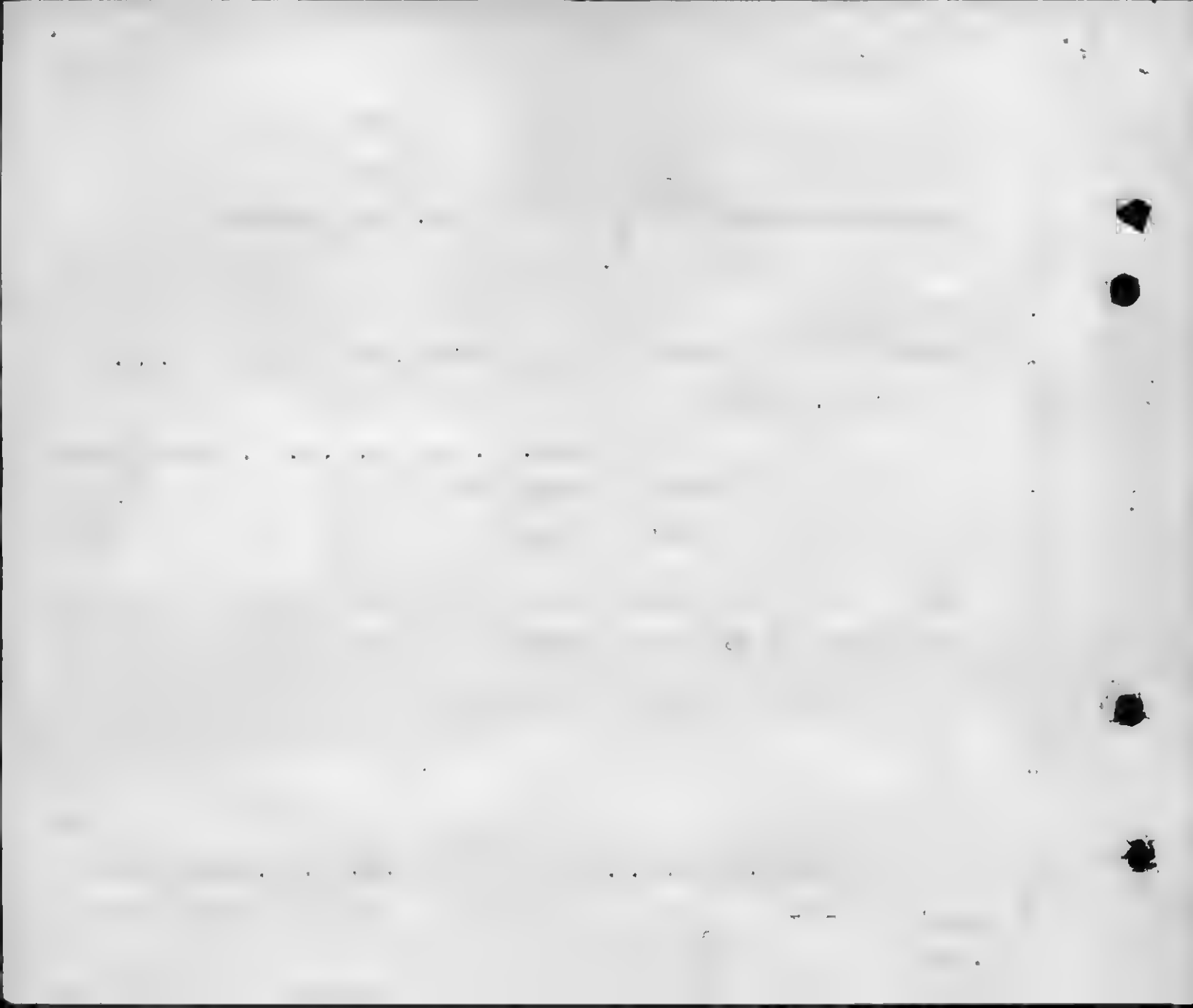
1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician.

FOR SHIPMENT TO: STEPHENS FUNERAL HOME, LUMBERTON, NO. CAROLINA

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8800											
CERTIFICATE OF DEATH											
08793											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 838 N. Chapelgate Lane							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 Days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital											
3. NAME OF DECEASED (Type or print) DALCHO				C. BAILEY				4. DATE OF DEATH AUGUST 19 19 61			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Hardware				8. DATE OF BIRTH 7/23/14			
13. FATHER'S NAME Rufus A. Bailey				14. MOTHER'S MAIDEN NAME Leona Arnette				9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days Hours Min. 19 19 61			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II				11. BIRTHPLACE (Country & State, or foreign country) Marietta, North Carolina			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) HEMORRHAGIC PANCREATITIS DUE TO 581.1 Condition, if any, which gave rise to immediate cause (b) LAENNEC'S CIRRHOSIS DUE TO 581.1 (c) 581.1				12. CITIZEN OF WHAT COUNTRY? U.S.A.				17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Brain Syndrome, Delirium Tremens											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. 18, MD. FT. HOWARD DIVISION											
20f. (City or town) Lumberton, North Carolina (County) (State)											
21. I certify that 11 (this hospital) attended the deceased from 8/15/1961 to 8/19/1961 , that 11 (we) last saw the deceased alive on 8/19/61 and that death occurred at 6:40 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles E. Rowan											
22b. DATE SIGNED 8/19/61											
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN, M.D.											
22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal											
23b. DATE THEREOF 8-20-61											
23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery											
23d. LOCATION (City, town or county) Lumberton, North Carolina (State)											
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc											
25a. REC'D BY REGISTRAR AUG 22 '61											
25b. REGISTRAR'S SIGNATURE Charles E. Rowan											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8801

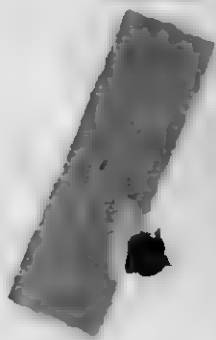
CERTIFICATE OF DEATH

08294

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY in lb 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 6323 BOSTON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) OBEDE R. BAKER		4. DATE OF DEATH Month AUGUST Day 3 Year 1961					
5. SEX Male		6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1894					
9. AGE (In years last birthday) 66 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 11. BIRTHPLACE (Country & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
13. FATHER'S NAME John T. Baker		14. MOTHER'S MAIDEN NAME Annie L. Appleby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213-09-9241 17. INFORMANT Clinical Records, VAH, Balto. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) OLD MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS CIRCUMFLEX ARTERY DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC OBSTRUCTIVE HYPERTROPHIED EMPHYSEMA. BRONCHOPNEUMONIA, BILATERAL							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (x) (this hospital) attended the deceased from July 20 19 61 to August 3 19 61 , that (x) (we) last saw the deceased alive on August 3 , 19 61 , and that death occurred 3:20AM from the causes and on the date stated above.							
22a. SIGNATURE SEBASTIAN RUSSO, M.D.		22b. DATE SIGNED 8/3/61					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/61					
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home, 5305 Harford Rd. Baltimore, Md.		25a. REC'D BY REGISTRAR AUG 8 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained in the hospital or attended by the attending physician, the certificate may be retained in the hospital or attended by the attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
8802
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08795

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Owings Mills**

c. LENGTH OF STAY IN lb **5 years**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Rosewood State Training School**

2. USUAL RESIDENCE (Where deceased lived If institution: Reveal admission)
a. STATE **Maryland** b. COUNTY **St. Mary's**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Great Mills**

d. STREET ADDRESS **-**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)
First **Leola** Middle **-** Last **Barber**

4. DATE OF DEATH
Month **8** Day **23** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **Negro** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **? 1917** 9. AGE (In years lost birthday) **? 44 yrs.** IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Dependent** 10b. KIND OF BUSINESS OR INDUSTRY **-** 11. BIRTHPLACE (State or foreign country) **St. Marys County** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **John Beale** 14. MOTHER'S MAIDEN NAME **Mary Louise Green**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **-** 17. INFORMANT **Rosewood Records, Owings Mills, Md.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Dx (a) Infarction of myocardium due to arterio-sclerotic coronary thrombosis**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) **-**
(c) **-**
INTERVAL BETWEEN ONSET AND DEATH **10 hrs.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **-** 19. WAS A POSTMORTEM PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 **19** 20d. INJURY OCCURRED While of work ☐ Not while of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from **1/10** 19**56** to **8/23** 19**61**, that (I) (we) last saw the deceased alive on **8/23** 19**61**, and that death occurred at **6:20 p.m.** from the causes and on the date stated above.

22a. SIGNATURE **Edward J. Mathews** M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) **Edward J. Mathews, M.D.** 22d. ADDRESS **Rosewood State Training School Owings Mills, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **9-1-61, Mt. Airy Burial** 23b. DATE THEREOF **9-1-61** 23c. NAME OF CEMETERY OR CREMATORY **Baltimore, Md.** 23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE **James H. Newell** ADDRESS **Pikes & 2nd** 25a. REC'D BY REGISTRAR **SEP 6 '61** 25b. REGISTRAR'S SIGNATURE **William S. Harris**

*James H. Brown
P.O. Box 2*

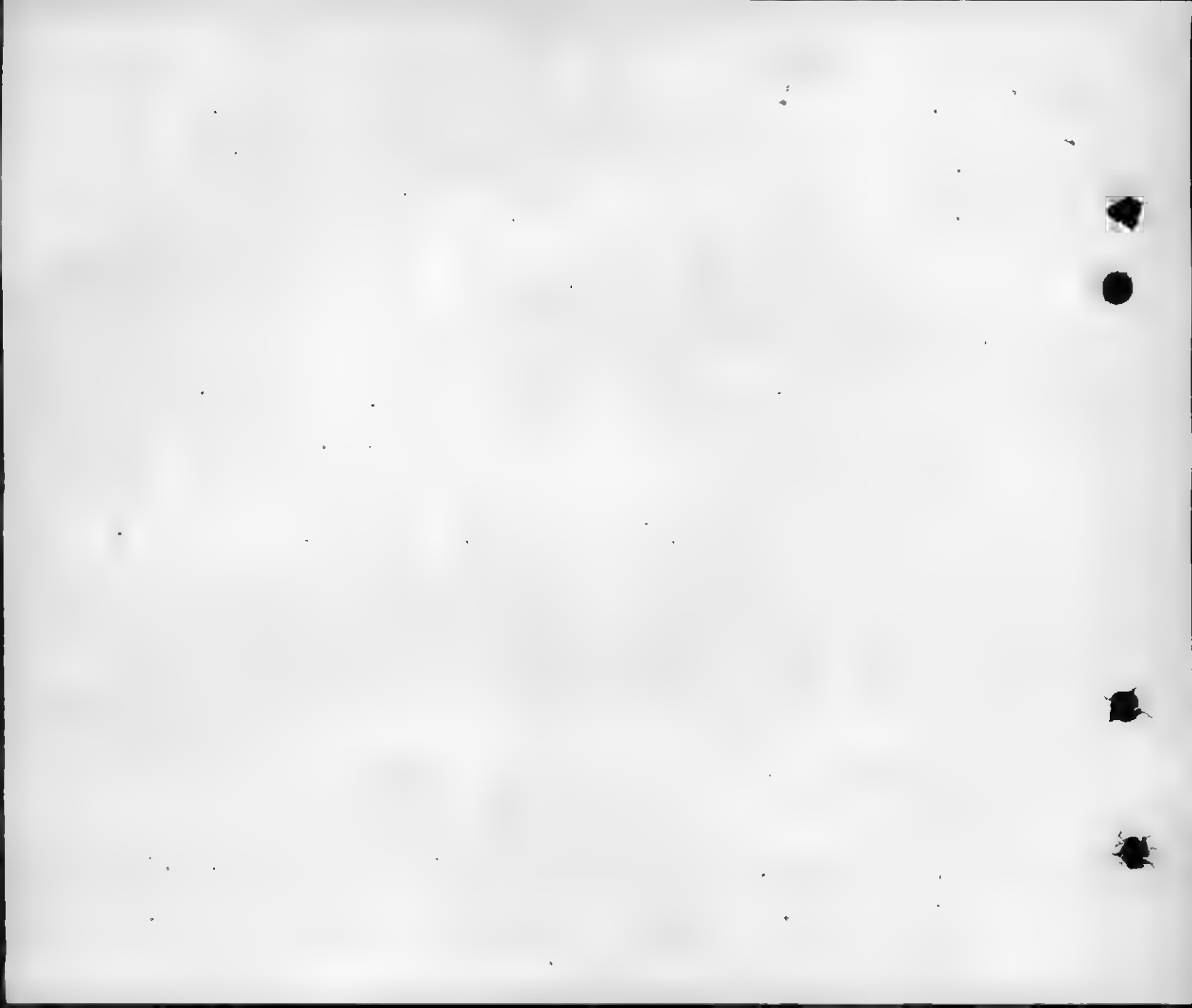


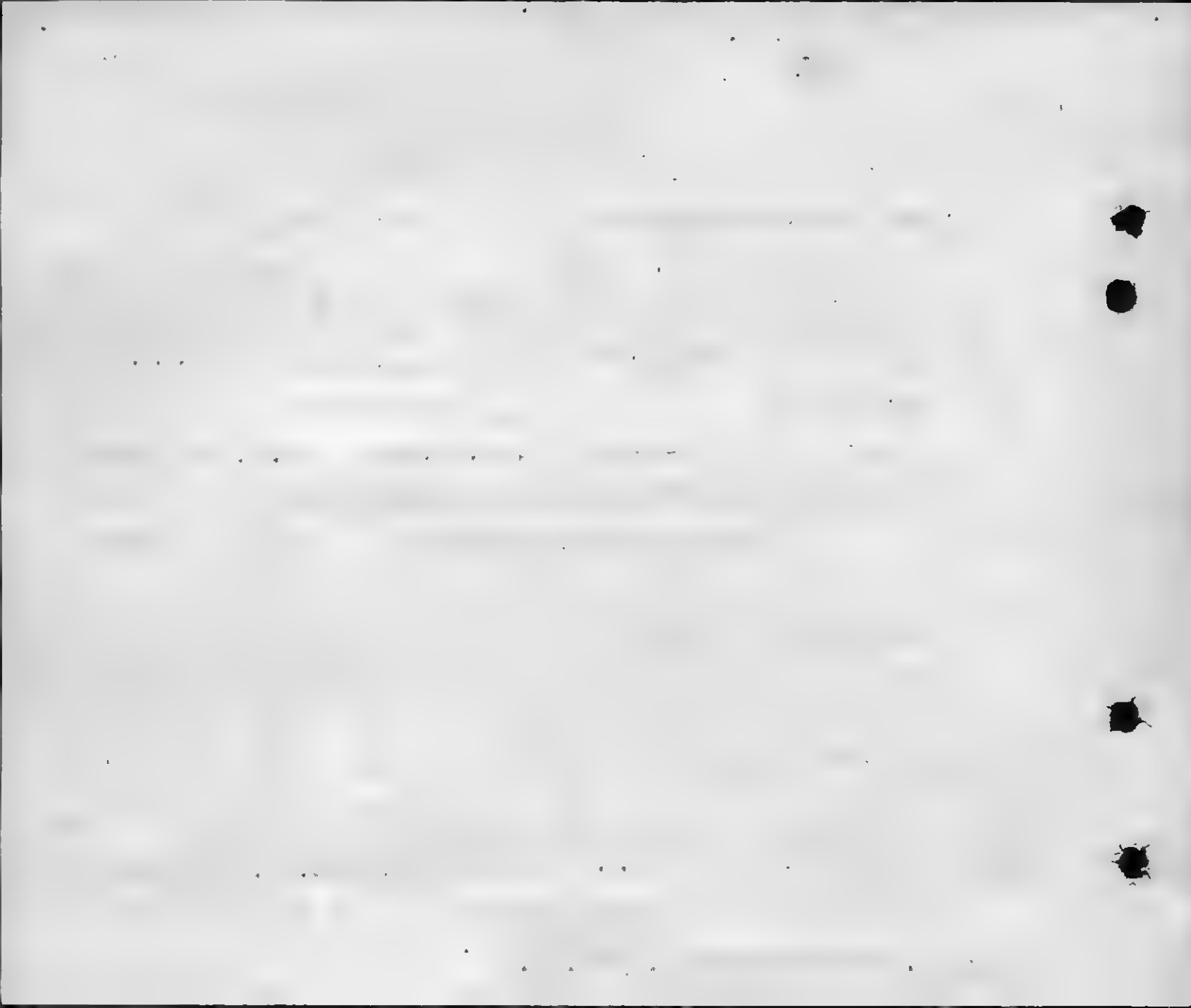
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880

08797

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 1 mo. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		1 x 1 1/2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS c/o Post office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH		First		Middle MERVIN		Last BARNES	
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month 8 Day 6 Year 1961	
8. DATE OF BIRTH 10.12.12.		9. AGE (In years last birthday) 48 yrs		IF UNDER 1 YEAR Months 8 Days 6		IF UNDER 24 HRS Hours 10 Min 15	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH BARNES				14. MOTHER'S MAIDEN NAME ROSEMA EDISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Far advanced bilateral pulmo- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last nary tuberculosis (b) Far advanced bilateral pulmo- (c) nary tuberculosis							INTERVAL BETWEEN ONSET AND DEATH 20 min 8 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7.3.1961 to 8.6.1961 , that (I) (we) last saw the deceased alive on 8.6.1961 , and that death occurred at 9:25 from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE 8.6.1961	
22c. PHYSICIAN'S NAME (Type) Mr. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/10/61		23c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		23d. LOCATION (City, town, or county) (State) Great Mills, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				25a. REC'D BY REGISTRAR AUG 10 '61		25b. REGISTRAR'S SIGNATURE Christina S. Thomas	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8805

CERTIFICATE OF DEATH

Reg. Dist. No. 08798

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home				d. STREET ADDRESS 2519 School House Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LOUISA		First LOUISA		Middle +++		Last BEARMAN	
4. DATE OF DEATH AUG. 5 1961		Month AUG.		Day 5		Year 1961	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1881	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Koester				14. MOTHER'S MAIDEN NAME Catherine (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Melvin R. Bearman		Address 26 Portship Road Baltimore 22, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 2/21 , 19 59 , to 8/5 , 19 61 , that I last saw the deceased alive on 8/5 , 19 61 , and that death occurred at 2:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Samuel Stern M.D. _____ PHYSICIAN'S NAME (Type) SAMUEL STERN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/8/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore Co., Maryland (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md ADDRESS _____				24a. REC'D BY REGISTRAR AUG 8 '61 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

880S

08799

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shadybrook Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2827 Harlem Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophia Beehler</u> 5. SEX <u>Female</u> 6. CO. OR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 17, 1873</u> 9. AGE (In years, if under 1 year, if under 24 hrs.) Last birthday: <u>87</u> yrs. Months <u>1</u> Days <u>4</u> Hours <u>19</u>		4. DATE OF DEATH <u>Aug. 15/61</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Beehler</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Warren A. Arnold</u> Address <u>17 E. Saratoga St.</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Bender</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>Aug 13, 1961</u> Hour a.m. <u>7:15</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4116 Edmondson Ave., Balto., Md.</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1960</u> to <u>Aug 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 14, 1961</u> , and that death occurred at <u>7:20</u> A.M. from the causes and on the date stated above. 22a. SIGNATURE <u>George A. Knipp</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>Aug 16 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>George A. Knipp, M.D.</u> 22d. ADDRESS <u>4116 Edmondson Ave., Balto., Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/18/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lauson Park</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F. K.</u> ADDRESS <u>4101 Edmondson Ave.</u> 25a. REC'D BY REGISTRAR <u>Aug 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician, if the death occurred in the hospital or in the home, complete and sign this certificate. The attending physician or hospital director, if the death occurred in the hospital, should be designated as the informant. The funeral director, if the death occurred in the home, should be designated as the informant. The funeral director, if the death occurred in the home, should be designated as the informant. The funeral director, if the death occurred in the home, should be designated as the informant.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8807

CERTIFICATE OF DEATH

118800

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> c. LENGTH OF STAY IN 1b <u>257 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7910 Bridge Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> d. STREET ADDRESS <u>7910 Bridge Ave.</u> e. (IS RESIDENCE ON A FARM?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Barbara Marie</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. WIDOWED <input type="checkbox"/> j. DIVORCED <input type="checkbox"/>		4. DATE OF DEATH k. DATE OF BIRTH <u>Dec. 29, 1883</u> l. AGE (In years, last birthday) <u>72</u> yrs. m. IF UNDER 1 YEAR: Months <u>5</u> Days <u>14</u> Hours <u>24</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE County & State, or foreign country <u>Balto. Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Cumberland</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Kellner</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>Agnes M. Amberson</u> Address <u>830 S East Ave 2nd 24</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arterio Sclerotic Cardio Vascular</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <u>1961</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1961</u> to <u>8/4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>61</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Barbara Marie</u> M.D. <u>8/4/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Baltimore Md</u> 22d. ADDRESS <u>Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cwach</u> ADDRESS <u>1211 Chesaco Ave.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u> DATE <u>AUG 8 '61</u> 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is complete. To FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

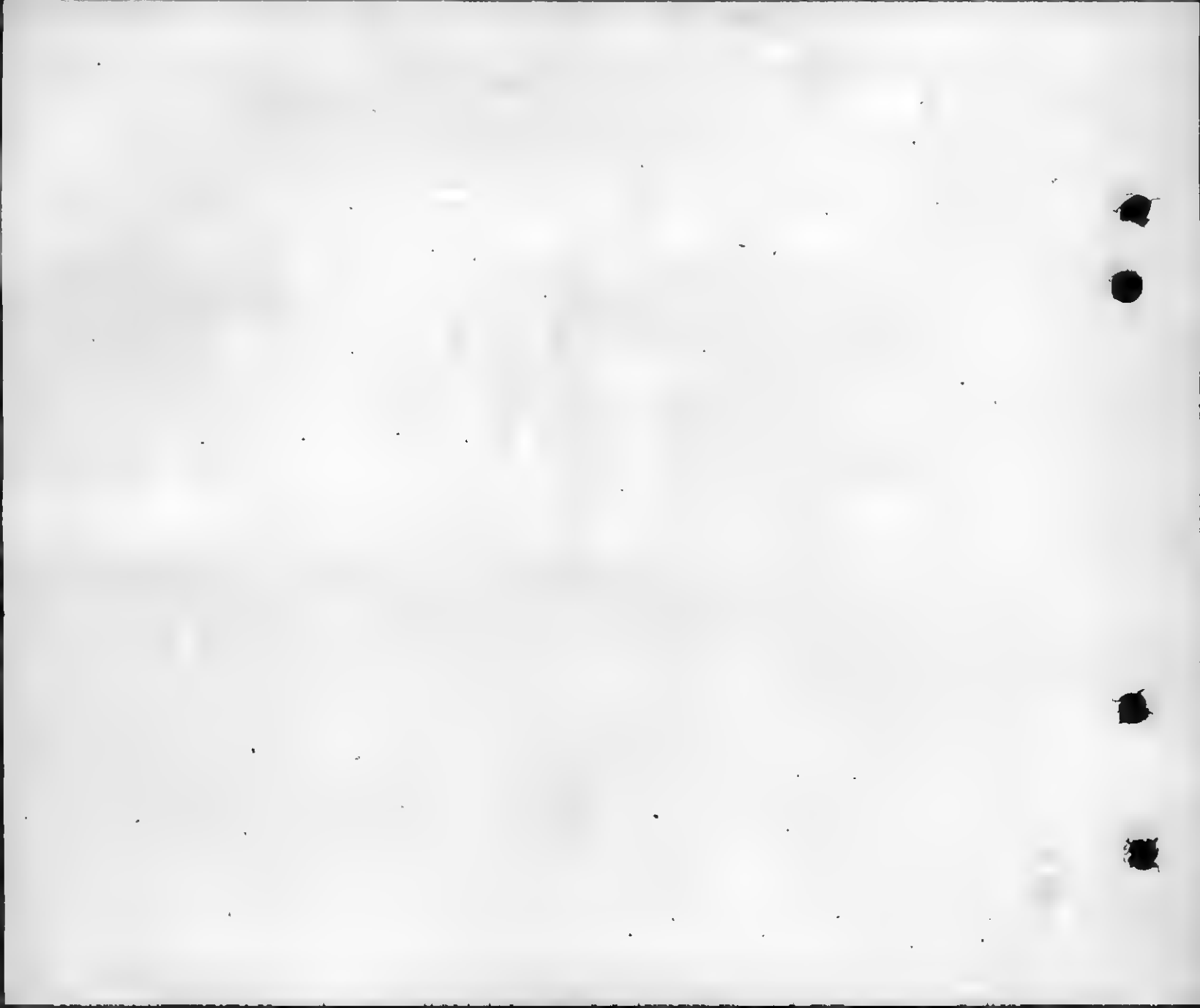
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ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 188111

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL c. LENGTH OF STAY IN 1b 72 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bernoudy Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL d. STREET ADDRESS Bernoudy Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOREN A. Middle A. Last BERNOUDY		4. DATE OF DEATH Month August Day 19 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1866	9. AGE (In years last birthday) 94 yrs.	10. IF UNDER 1 YEAR Months 94 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN R. MILLER			
14. MOTHER'S MAIDEN NAME ANN MARY FREDRICK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. ---		17. INFORMANT Mazie E. Gillette Address WHITE HALL MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular renal disease DUE TO (b) 11/2 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ---					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to Aug 19, 1961 that I last saw the deceased alive on Aug 19, 1961 and that death occurred at 6 PM from the causes and on the date stated above.					
ACTUAL SIGNATURE A. M. France M.D.		DATE SIGNED 8/19/61			
PHYSICIAN'S NAME (Type) A. M. FRANCE		ADDRESS (Street, city or town, state) PARKTON, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 22, 1961		22c. NAME OF CEMETERY OR CREMATORY WISBURG CEMETERY	
22d. LOCATION (City, town, or county) (State) White Hall Md.		23. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein Address New Freedom, Pa.		24a. REC'D BY REGISTRAR DATE AUG 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume					



1
14
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8809

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118802

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1303 Pineridge Terrace		d. STREET ADDRESS 1303 Pineridge Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle BERNSTEIN Last		4. DATE OF DEATH Month August Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1901
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Chemical	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Bernstein		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 217-01-1567	
17. INFORMANT Address Mrs. Gertrude Bernstein- 1303 Pineridge Terrace			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Coronary Insufficiency DUE TO (c) Hypertension, a S. C. U. Disease.		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1958 to Aug 4 1961, that (I) (we) last saw the deceased alive on July 29 1961, and that death occurred at 6 A M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Bernard Cohen		22b. DATE SIGNED 8/4/61	
22c. PHYSICIAN'S NAME (Type) Dr. Bernard Cohen		22d. ADDRESS 3501 St Paul Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 6/61	
23c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. ADDRESS 6010 Reister Road		25a. REC'D BY REGISTRAR DATE AUG 8 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Brand	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8810

06803

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN It 2 Mts. 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland
d. STREET ADDRESS Box 510 RT. 14 Baltimore 20
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Edna Borchers MARY Borchers
First Middle Last
4. DATE OF DEATH 8 26 19 61
Month Day Year
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH 12 13 - 1886
9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (County & State, or foreign country) Maryland, BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME XXXXXXXXX HENRY WEHRMAN
14. MOTHER'S MAIDEN NAME XXXXXXXXX MARY UHL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No
(Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 12 07 2892 B
17. INFORMANT MR. HARRY J. BORCHERS RT. 14, BOX 511 BALTO 20
Address Records : Spring Grove Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency
DUE TO (c) Coronary and Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
hours —
? —
years —

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 6 6 19 61 to 8 26 19 61 that (I) (we) last saw the deceased alive on 8 26 19 61 and that death occurred at 5:30 PM from the causes and on the date stated above.

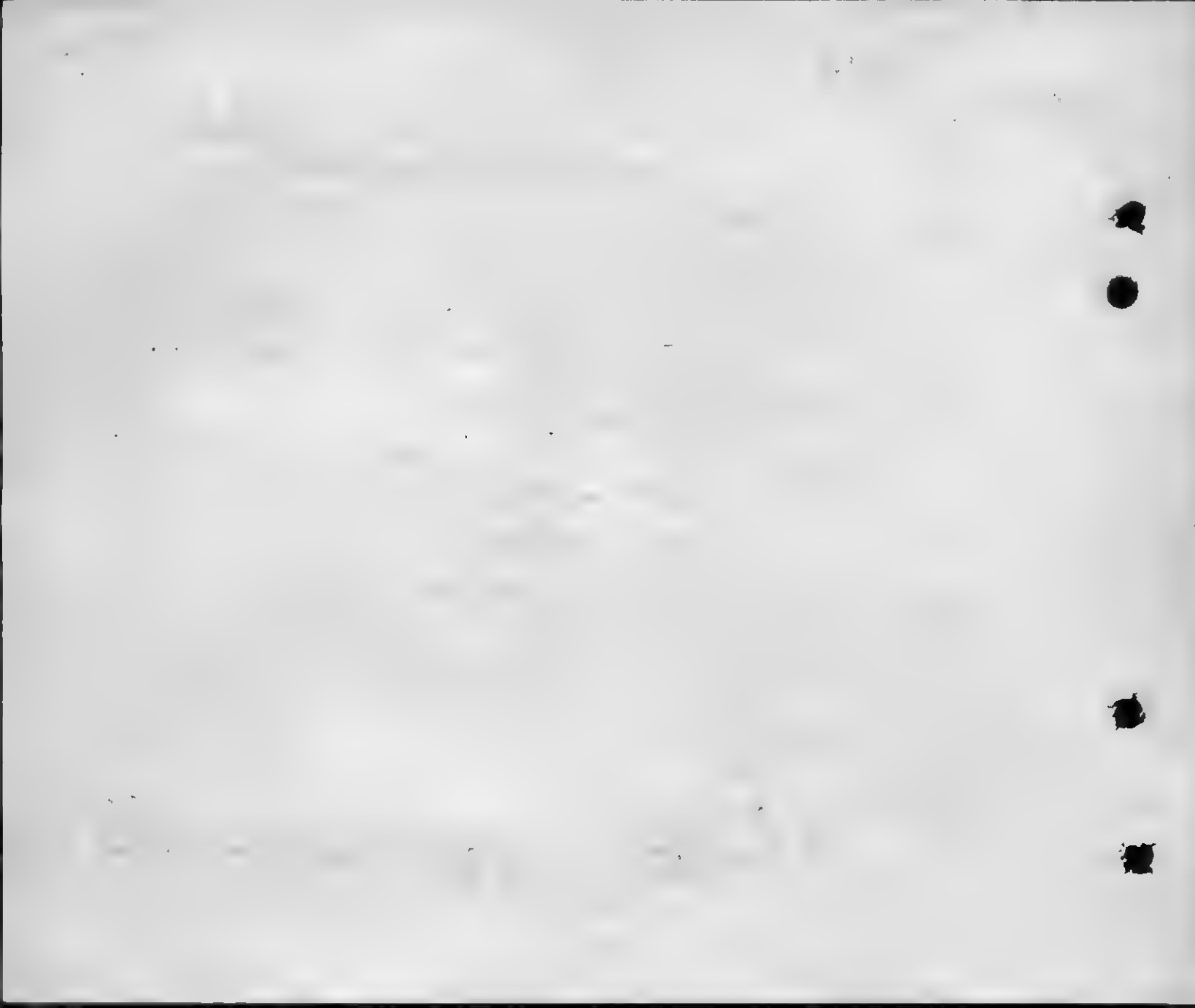
22a. SIGNATURE P. Ki-Yun Yip
22c. PHYSICIAN'S NAME (Type) P. KI-YUN YIP
22b. DATE SIGNED 8/27/61
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 8/30/61
23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY
23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY SANDER & SONS INC. BALTO. MD.
25a. RECEIVED BY REGISTRAR AUG 29 1961
25b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician complete and file in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed. The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician complete and file in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



881 STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Baltimore

Village or City Towson

Registration Dist. No. 118804

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U.S. if of foreign birth?

Yrs.

Mos.

Ds.

2. FULL NAME CATHERINE M. BRENNAN

If U. S. Veteran, specify WAR

(a) Residence: No. 4904 ALSON DRIVE

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Single

6. DATE OF BIRTH (month, day, and year) Jan. 24, 1878

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

83

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Ass't Treas.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Emerson Drug Co.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto. Md.
(State or country)

MOTHER FATHER

13. NAME Thomas Brennan

14. BIRTHPLACE (city or town)
(State or country)

15. MAIDEN NAME Margaret Mitchell

16. BIRTHPLACE (city or town)
(State or country)

17. INFORMANT Mrs. John P. Ryan
(Address) Cambridge Arms Apt.

18. BURIAL, CREMATION, OR REMOVAL
Place New Cathedral Date 8/16/61

19. UNDERTAKER Witzke F.B. 4101 Edmondson Ave
(Address)

20. FILED AUG 15 '61
Arthur S. Harris

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

AUGUST 12, 1961

(Month)

(Day)

19361
(Year)

22. I HEREBY CERTIFY, That I attended deceased from
JUNE 1 1959, 1959, to AUGUST 12, 1961.

I last saw her alive on AUGUST 12, 1961; death is said to have occurred on the date stated above, at 4:40 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

CARCINOMIA OF SIGMOID FLEXURE

Date of onset
JUNE 1

CHRONIC MYOCARDITIS

1959

ARTERIOR SCLEROSIS

1959

METASSIS

1960

Other Contributory Causes of Importance:

Name of operation RESECTION COLON Date JUNE 27 1961

What test confirmed diagnosis? MISCROSCOPE Was there an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify NO

(Signed)

Charles J. Cloutier

M. D.

(Address) 3013 SAINT PAUL STREET

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with
page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8812
CERTIFICATE OF DEATH

18805

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 6 WEEKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMETT Middle ELMO Last BROOKS		4. DATE OF DEATH Month AUGUST Day 3 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19 1913
9. AGE (In years lost birthday) 48 yrs		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEONARD BROOKS		14. MOTHER'S MAIDEN NAME NANNY BROOKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 223-18-9207	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL INFARCTION RIGHT CEREBRAL HEMISPHERE DUE TO CEREBRAL VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 6 MONTHS DUE TO PULMONARY TUBERCULOSIS ACTIVE 1 1/2 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 1 1/2 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19 1961 to 8/3 1961 , that (I) (we) last saw the deceased alive on 8/3 1961 , and that death occurred at 8/3 1961 , from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer, M.D.		22b. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-3-61		23b. DATE THEREOF 8-3-61	
23c. NAME OF CEMETERY, OR CREMATORY Graves Chapel Cemetery		23d. LOCATION (City, town, or county) (State) Shirley, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Bradley Funeral Home		25. REC'D BY REGISTRAR AUG 10 '61	
25a. ADDRESS Shirley, Va		25b. REGISTRAR'S SIGNATURE William B. Fennell	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8813

CERTIFICATE OF DEATH

08806

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>LANSDOWNE</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>121 HAZEL AVE.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u> d. STREET ADDRESS <u>121 HAZEL AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK M. BROWN</u> First Middle Last		4. DATE OF DEATH <u>AUG. 29 1961</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/23/85</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>BYD RET.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK A. BROWN</u> 14. MOTHER'S MAIDEN NAME <u>DUNN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Agnes F. Brown</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u> (b) <u>Arteriosclerotic CVD</u> (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>0 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>6/2 1961</u> to <u>8/29 1961</u> that (I) (we) last saw the deceased alive on <u>8/29 1961</u> and that death occurred at <u>2A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D. 22b. DATE SIGNED <u>SEP 5 '61</u>				22c. ADDRESS <u>436 Washington Blvd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODON PK.</u>			
23d. LOCATION (City, town or county) <u>BALTO. MD.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <u>SEP 5 '61</u> <u>Arthur S. Kram</u>					

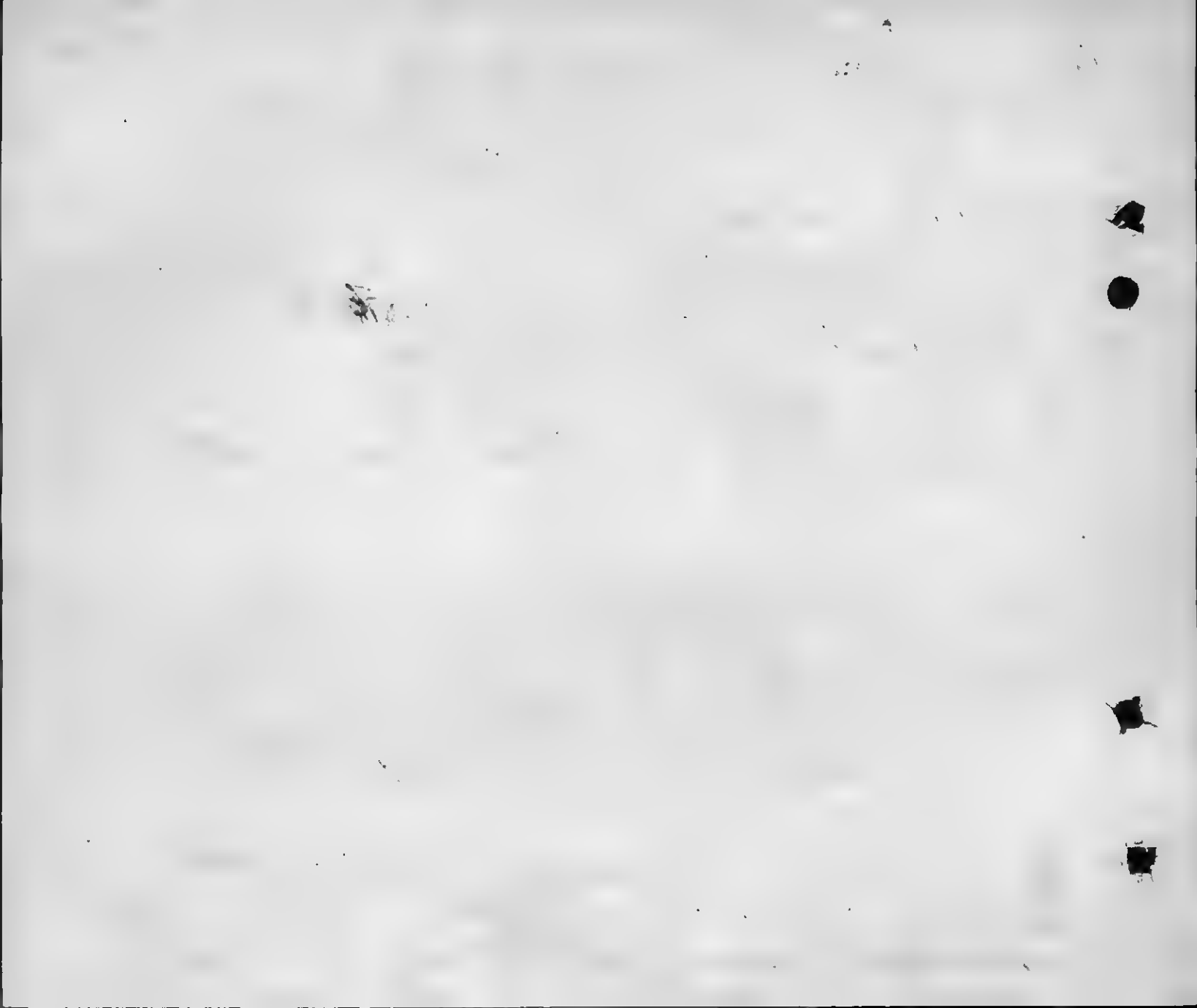
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician, if the death is reported to the health department, must file the certificate with the health department within 24 hours after death. The law also requires that the health department file the certificate with the State Department of Health within 24 hours after death. The law also requires that the health department file the certificate with the State Department of Health within 24 hours after death.



Items 6, 8, & 14 Film G293 8/22/61 mh

Arthur L. Krauss

YR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

18808

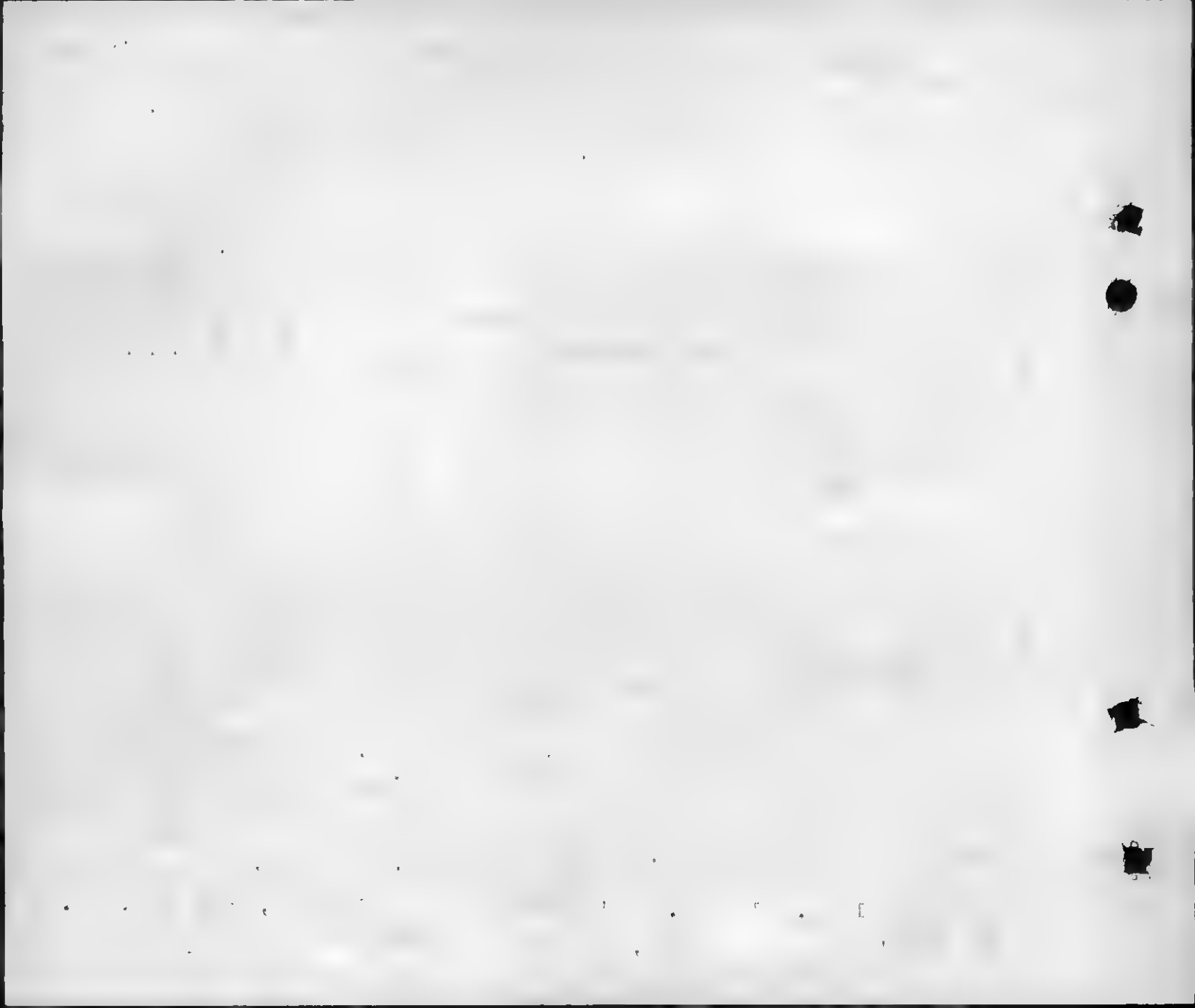
8815

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 3828 Tudor Arms Avenue	
3. NAME OF DECEASED (Type or print) First May Middle Theresa Last Butler		4. DATE OF DEATH Month Aug. Day 18 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/1865
9. AGE (In years last birthday) yrs. 96		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Butler		14. MOTHER'S MAIDEN NAME Cordelia Streett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Generalized Weakness Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. ASCVD DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. , 1960, to Aug. , 1961, that I last saw the deceased alive on Aug. 16 , 1961, and that death occurred at 2:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 602 E. Joppa Road. DATE SIGNED			
ACTUAL SIGNATURE Robert J. Mahon M.D.			
PHYSICIAN'S NAME (Type) Robert Mahon, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 21 Aug. 1961	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Pylesville, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		ADDRESS Towson, Maryland	
24a. REGISTRY REGISTRAR DATE Aug 21 61		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

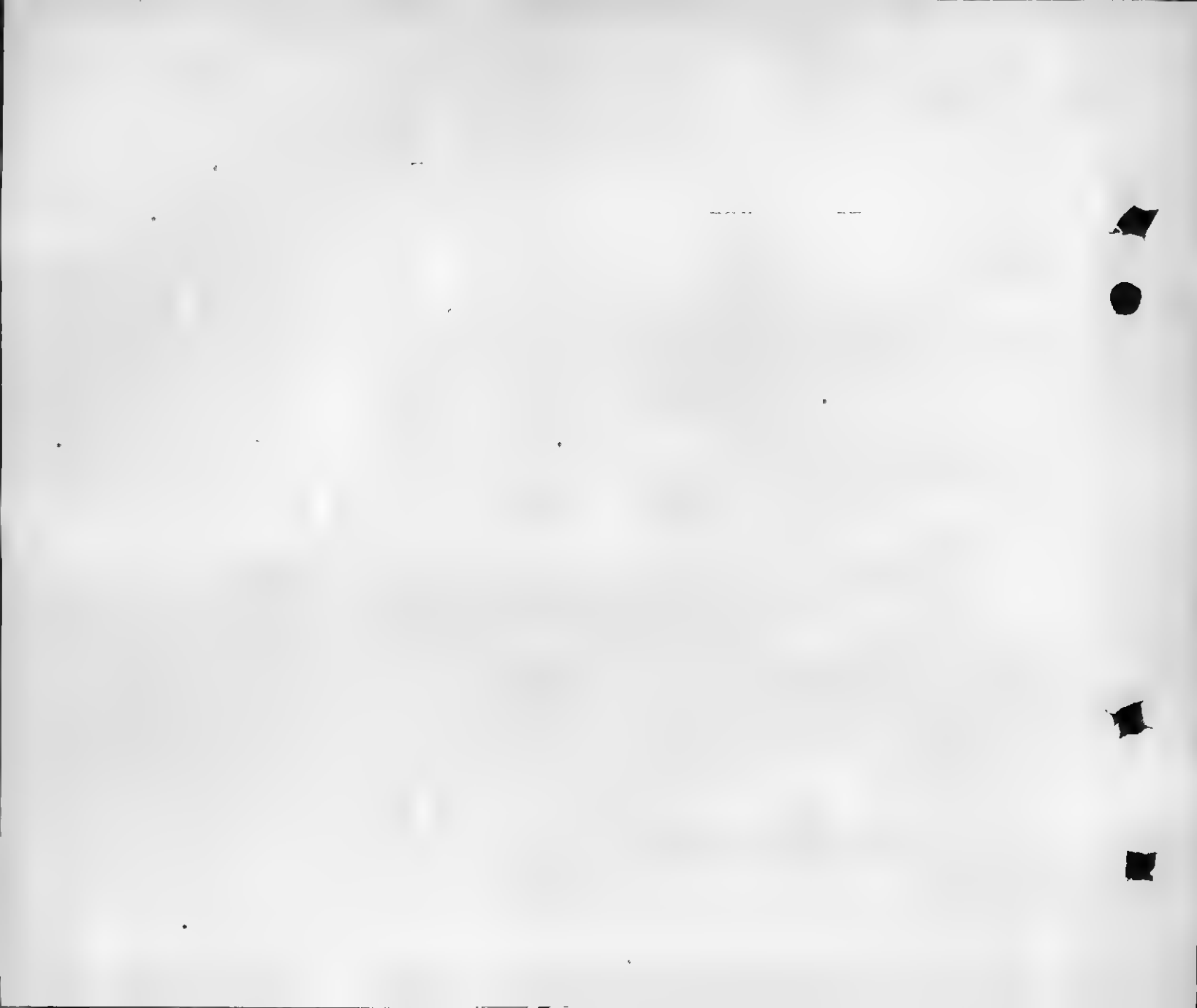
8815

CERTIFICATE OF DEATH

Reg. Dist. No.

08809

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b LIFE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - PHOENIX, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 DUDDINGTON, PHOENIX, Md.			
e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle CARROLL Last				4. DATE OF DEATH Month 8/5/61 Day Year 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 4, 1875	
9. AGE (In years last birthday) 86 yrs.		10. KIND OF BUSINESS OR INDUSTRY INVESTMENT BANKER		11. BIRTHPLACE (State or foreign country) BALTIMORE COUNTY		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY INVESTMENT BANKER			
13. FATHER'S NAME WILLIAM S. CARROLL				14. MOTHER'S MAIDEN NAME LOUISA TILGHMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT J. MARTIN McDONOUGH				Address - PHOENIX, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis C. U. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1 , 19 61 to 8-5 , 19 61 , that I last saw the deceased alive on 8-1 , 19 61 , and that death occurred at 8 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) YORK RD PARKTON MD DATE SIGNED 8/5/61							
ACTUAL SIGNATURE C. Herbert Mueller M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/7/61		22c. NAME OF CEMETERY OR CREMATORY IMMANUEL CEMETERY		22d. LOCATION (City, town, or county) (State) GLENCO, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. V. Moore				ADDRESS 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE AUG 7 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Thomas			



1
FOR STATE
HEALTH DEPT.

(M)

(I)

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VS. AISM
SM 9/60

1
FOR STATE
HEALTH DEPT.

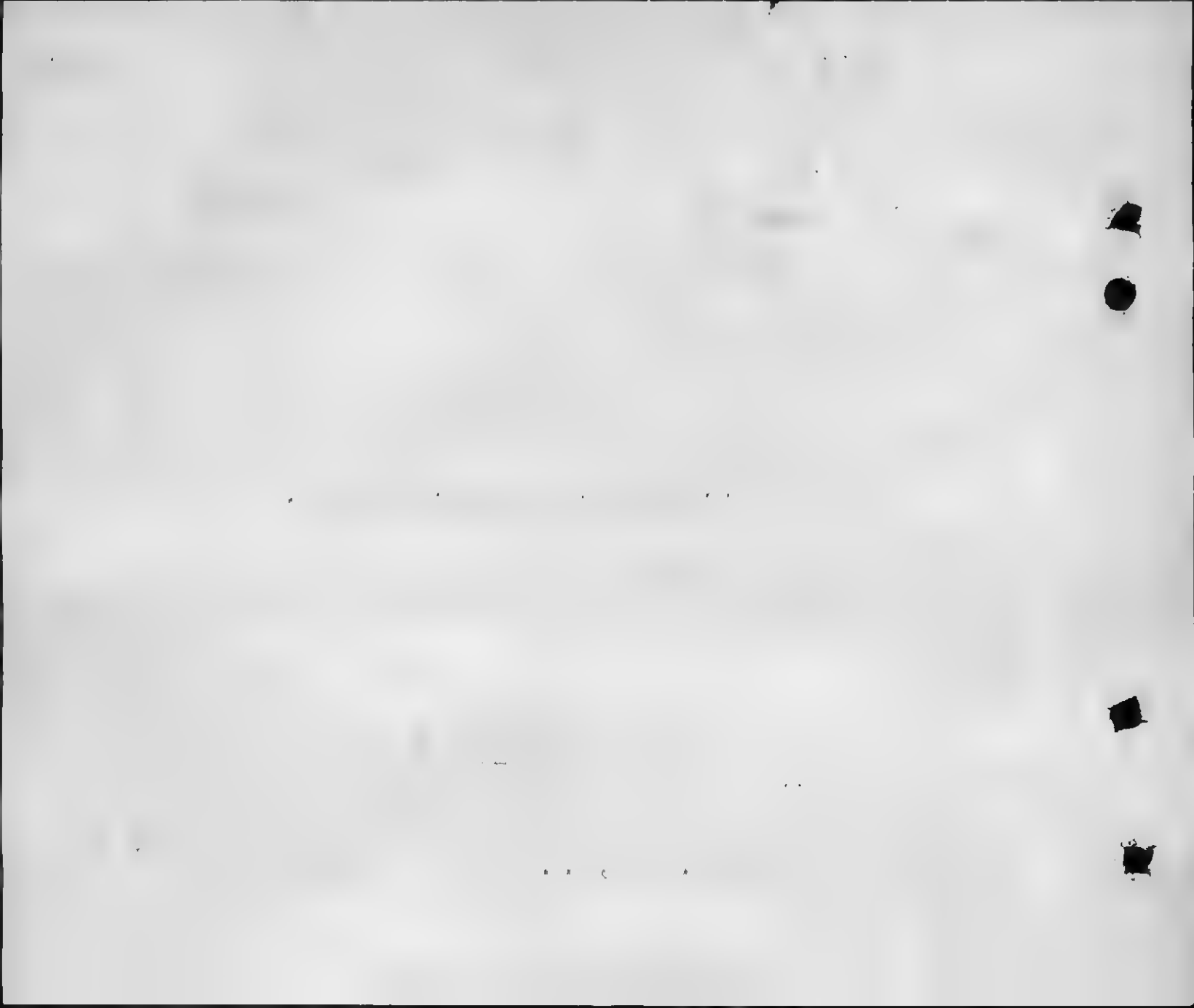
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08810

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1815 William Rd		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1815 William Rd	
3. NAME OF DECEASED (Type or print) JOSEPH GEORGE CARUSO		4. DATE OF DEATH August 2 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Federal Aviation Agency	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK		14. MOTHER'S MAIDEN NAME Mary Paulus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-22-8259	
17. INFORMANT Anna Maria Caruso		Address 1815 William Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Philip E. Crach		24a. REC'D BY REGISTRAR 1211 Chesaco Ave Baltg.	
24b. REGISTRAR'S SIGNATURE August 8 '61		DATE August 8 '61	

Charles S. Petty



8818

CERTIFICATE OF DEATH

Reg. Dist. No.

00811

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kingsville</u> b. COUNTY <u>Balto Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Johnson Chapman</u>		4. DATE OF DEATH <u>Aug 13th</u> 1961	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Kingsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jonathan J. Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Elizabeth Sauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war & dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Charlotte M. Gladden Kingsville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>10X Congestive Heart Failure</u> DUE TO (b) <u>Hypertrophy of Prostate G.</u> DUE TO (c) <u>Bill. Tract Infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>15 yrs.</u> <u>2 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal Ca. Scalp, Strangulated Femoral Hernia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16</u> 19 <u>45</u> to <u>8/13</u> 19 <u>61</u> that I last saw the deceased alive on <u>8/12</u> 19 <u>61</u> and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson M.D.</u>		ADDRESS (Street, city or town, state) <u>FORK, MD.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 15, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John Episcopal</u>	22d. LOCATION (City, town, or county) (State) <u>Kingsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Richer, Benson Md</u>		24a. REC'D BY REGISTRAR / 24b. REGISTRAR'S SIGNATURE <u>Arthur P. Frank</u>	
DATE <u>AUG 21 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08812

8819

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NRSg Home</u>		d. STREET ADDRESS <u>130 S. CULVER ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK (FRANCIS) D. CITY</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>8</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1876</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DVD R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. CITY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE REYNOLDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>MR. J. H. H. CITY</u>		Address <u>4301 G. ST. BALTIMORE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>retrocardiac Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 1/2 yrs</u> <u>5+ yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 7</u> , 19 <u>61</u> , to <u>Aug 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 7</u> , 19 <u>61</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6348 FREDERICK RD BALTIMORE MD</u> DATE SIGNED <u>Aug 8, 1961</u>			
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER MD BALTIMORE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. T. SCHWAB</u>		ADDRESS <u>3512 FREDERICK RD BALTIMORE MD</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8820

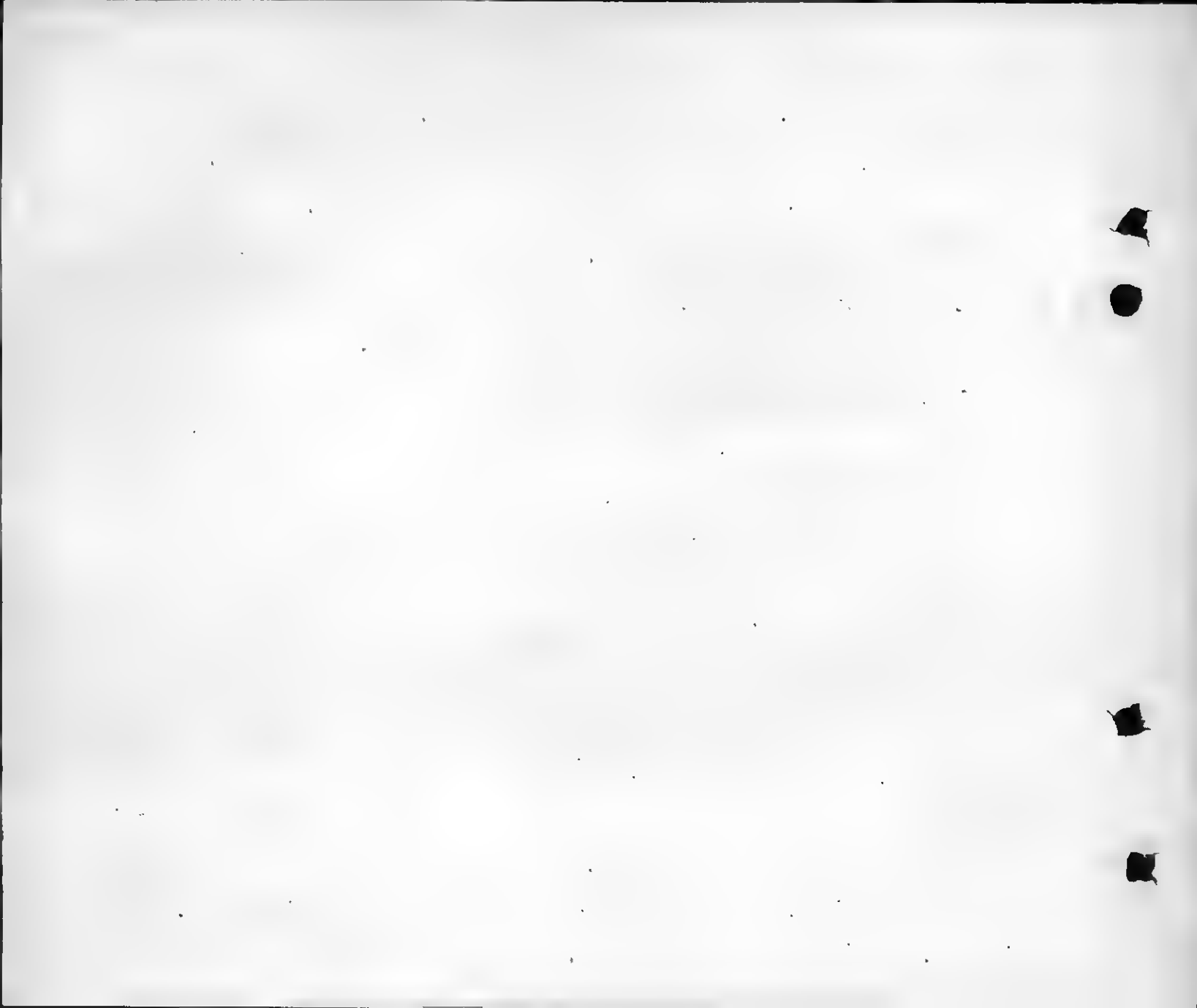
CERTIFICATE OF DEATH

Reg. Dist. No.

08813

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ensor Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claire</u> Middle <u>M.</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>8-20-1961</u> Day <u>19</u> Year <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1891</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas A. Morton</u>		14. MOTHER'S MAIDEN NAME <u>Deborah J. Newman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>078-10-8511</u>	
17. INFORMANT <u>ELIZABETH T. MORTON</u>		Address <u>OAKHURST N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Aug 20</u> , 19 <u>61</u> ; that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>61</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>8/21/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR <u>AUG 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

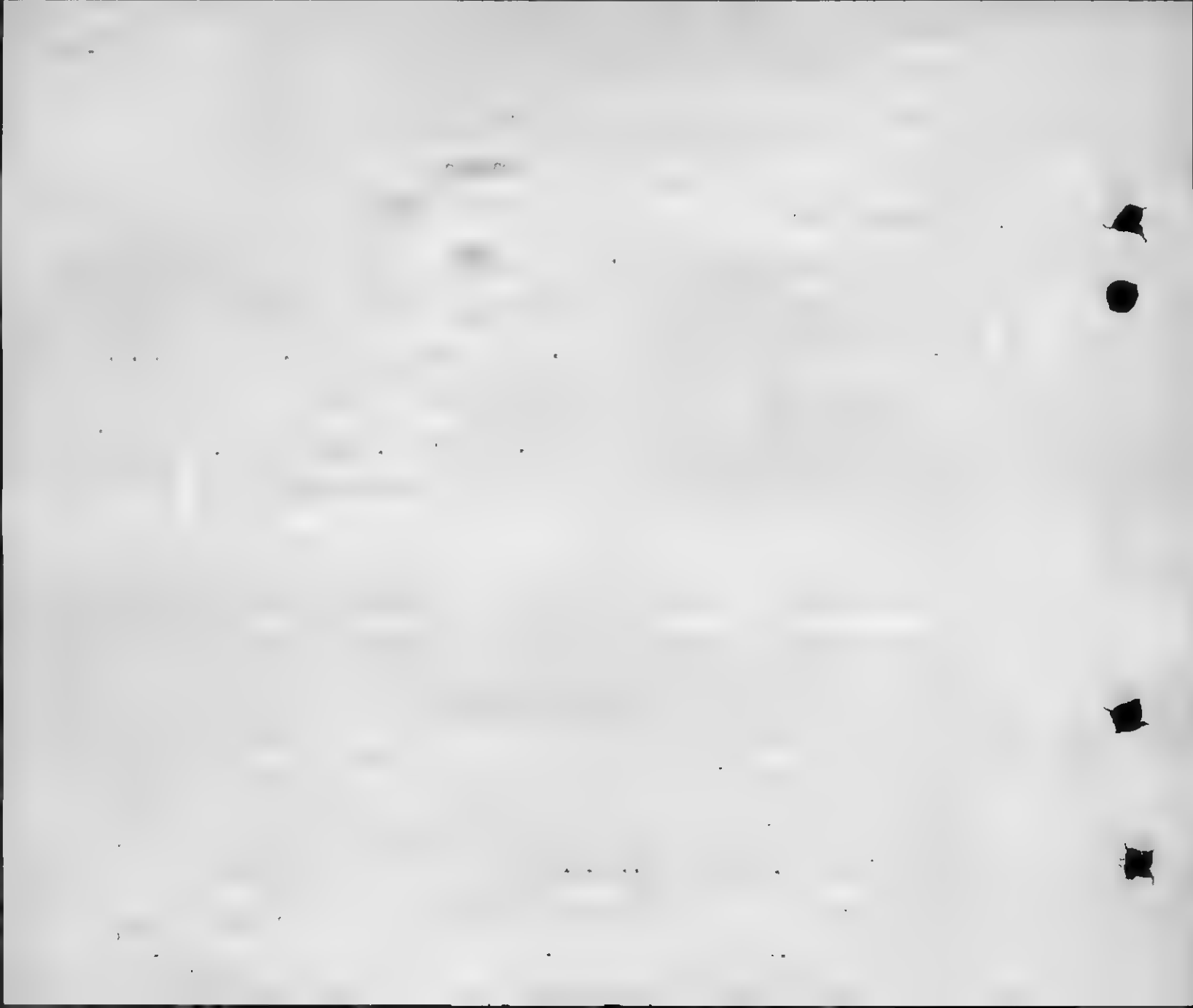
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5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108814

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8200 Pulaski Highway				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Oaklyn c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 170.3 d. STREET ADDRESS 118 E. Holly Street (6) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) HARRY A. COADY		4. DATE OF DEATH Month 8 Day 18 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1905		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5		11. IF UNDER 24 HRS. Hours 5 Min. 55			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Joseph Dixon Co.				11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Coady				14. MOTHER'S MAIDEN NAME Lillian Auchenlic				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 118 E. Holly Ave.				17. INFORMANT Mrs. Margaret T. Coady			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) 12.2.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 12.2.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12.2.1																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-19-61 ACTUAL SIGNATURE William V. Lovitt, Jr., M.D. EXAMINER'S NAME (Type) Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8-22-1961 22c. NAME OF CEMETERY OR CREMATORY Locustwood Memorial Park 22d. LOCATION (City, town, or county) (State) Earlston, New Jersey																			
23. FUNERAL DIRECTOR Lilly & Zeiler Inc., 1901 Eastern Ave.																			
24a. REC'D BY REGISTRAR AUG 22 '61 24b. REGISTRAR'S SIGNATURE Arthur S. H...																			



8822

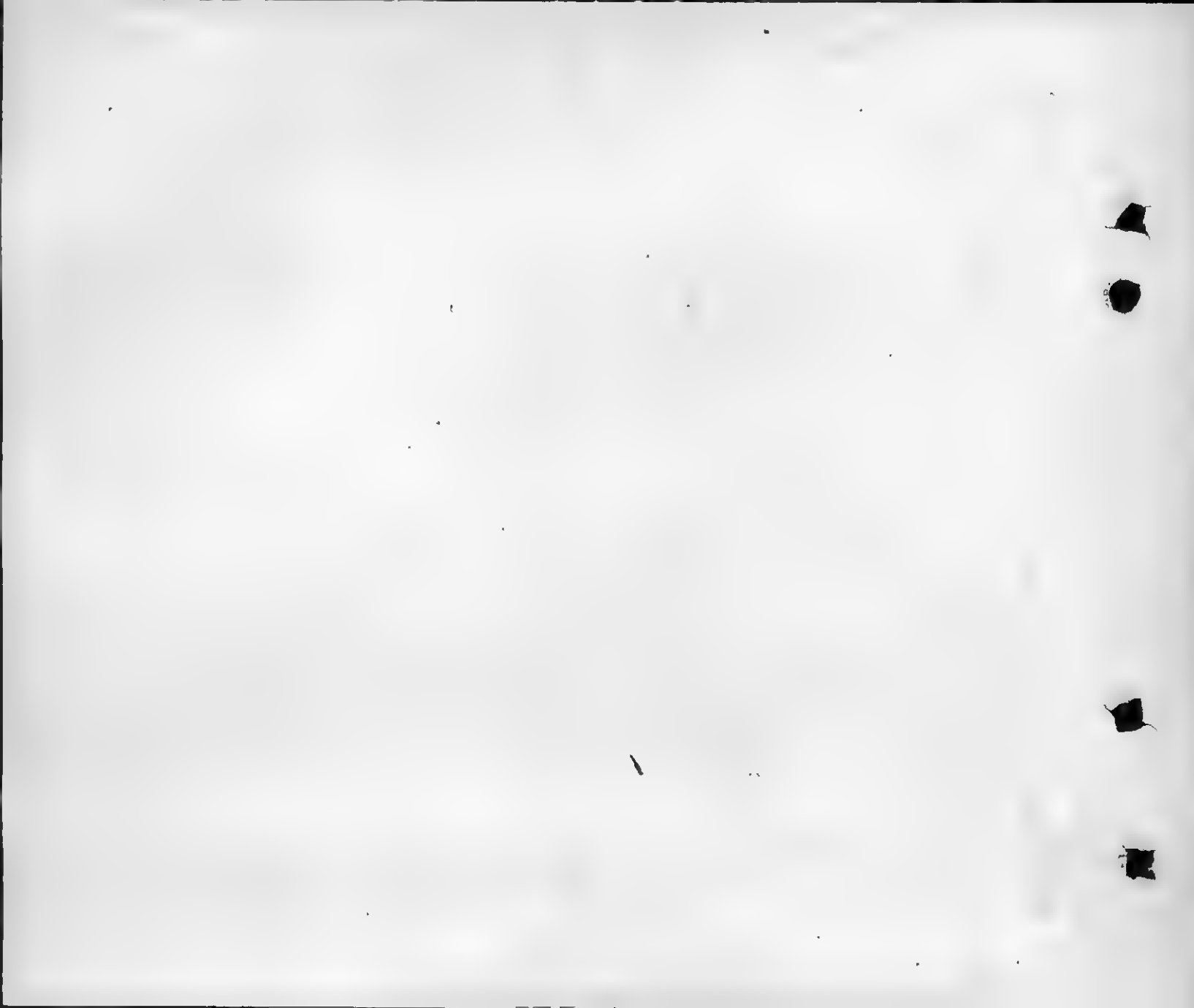
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08815

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2653 Purnell Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Delia Middle I. Last Cole		4. DATE OF DEATH Month Aug Day 13 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 5 Days 20	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hill		14. MOTHER'S MAIDEN NAME Margaret Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO 	
17. INFORMANT Mrs. Mary Schwarzkopf, 2653 Purnell Drive		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Hypertensive Cardio-Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Disease DUE TO Sclerosis (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Aug 13, 1961 , that (I) (we) last saw the deceased alive on Aug 13, 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE M Paul Byerly		22b. DATE SIGNED Aug 13, 1961	
22c. PHYSICIAN'S NAME (Type) M Paul Byerly		22d. ADDRESS 3083 W. North A Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-16-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE David R. Martin, 1902 Eutaw Place		25a. REC'D BY REGISTRAR DATE AUG 17 '61	
		25b. REGISTRAR'S SIGNATURE Arthur J. K. H. A.	

I

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or the hospital or attending physician.

M

I

MEDICAL CERTIFICATION

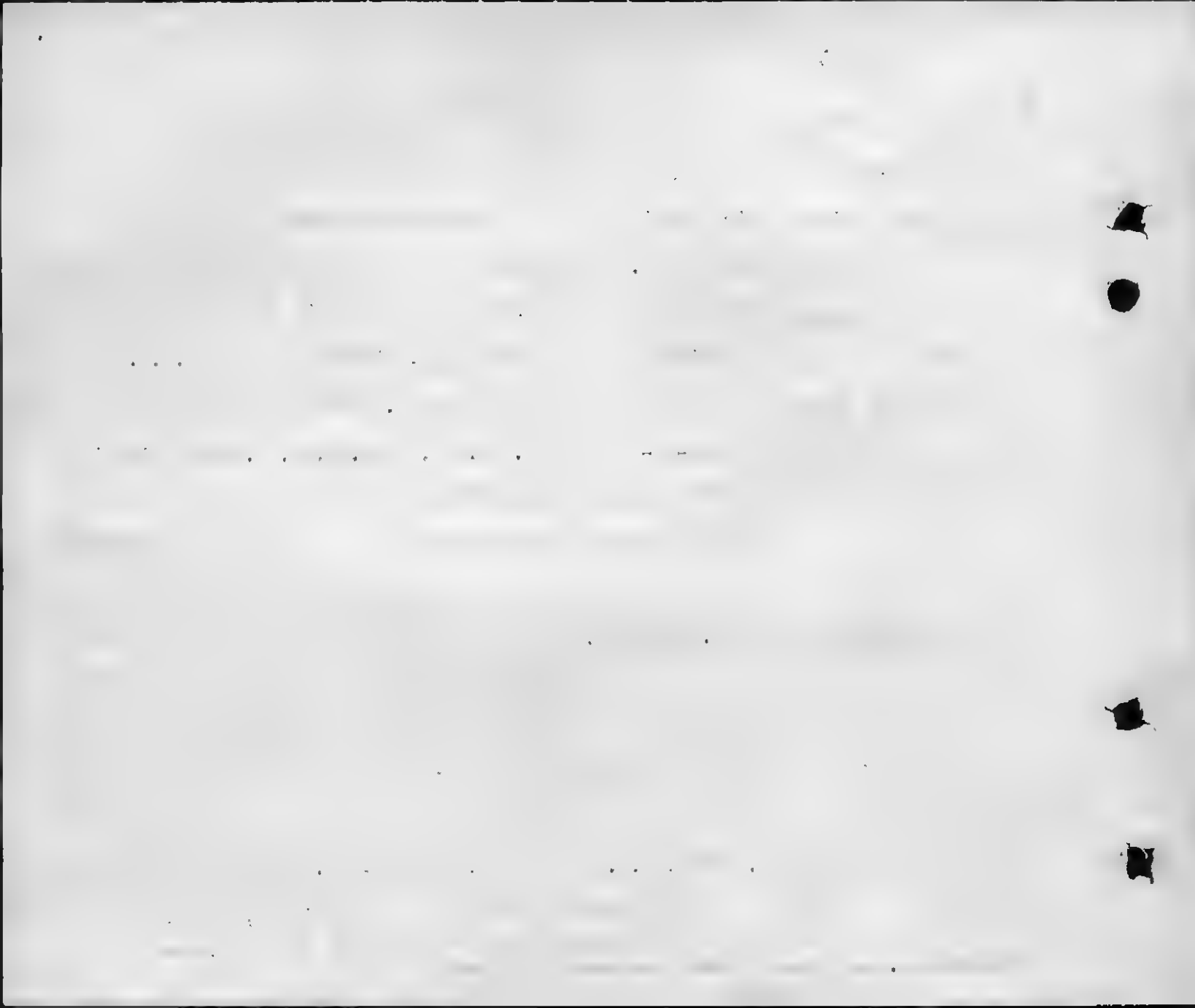
8823

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08816

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1202 Myrtle Avenue	
3. NAME OF DECEASED (Type or print) THOMAS L. COLLINS		4. DATE OF DEATH AUGUST 18 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/88
9. AGE (in years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Casanova, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mann		14. MOTHER'S MAIDEN NAME Mary V. Burner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Yes WW I		16. SOCIAL SECURITY NO. 226-18-2855	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHO PNEUMONIA (b) GENERALIZED ARTERIOSCLEROSIS (c) TUBERCULOSIS, RIGHT APEX. CYSTITIS.	
19. WAS AUTOPSY PERFORMED? YES		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 8/15/ 1961 , to 8/18/ 1961 , that (1) (we) last saw the deceased alive on 8/18/ 1961 , and that death occurred at 2:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Rowan		22b. DATE SIGNED 8/19/61	
22c. PHYSICIAN'S NAME (Type) Charles E. Rowan, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-23-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Funeral Home		25a. REC'D BY REGISTRAR AUG 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur J. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the attending physician and completed by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08817

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>				c. LENGTH OF STAY IN 1b <u>1 YR.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1145 CIRCLE DRIVE</u>				d. STREET ADDRESS <u>1145 CIRCLE DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF <u>LILLIE</u> First Middle Last (Type or print)				4. DATE OF DEATH <u>August 18, 1961</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 19, 1873</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HELEN DIERING</u> Address <u>1145 CIRCLE DRIVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accide</u> 11201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardio</u> DUE TO (c) <u>vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 to <u>Aug 18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>August 17, 1961</u> , and that death occurred at <u>3:30 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Norman Le Todd</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/18/61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>2108 St Paul St</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-21-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		23d. LOCAT ON (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schwan</u> ADDRESS <u>2101 Frederick Ave</u>				25a. REC'D BY REGISTRAR <u>AUG 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneib</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician. Complete filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

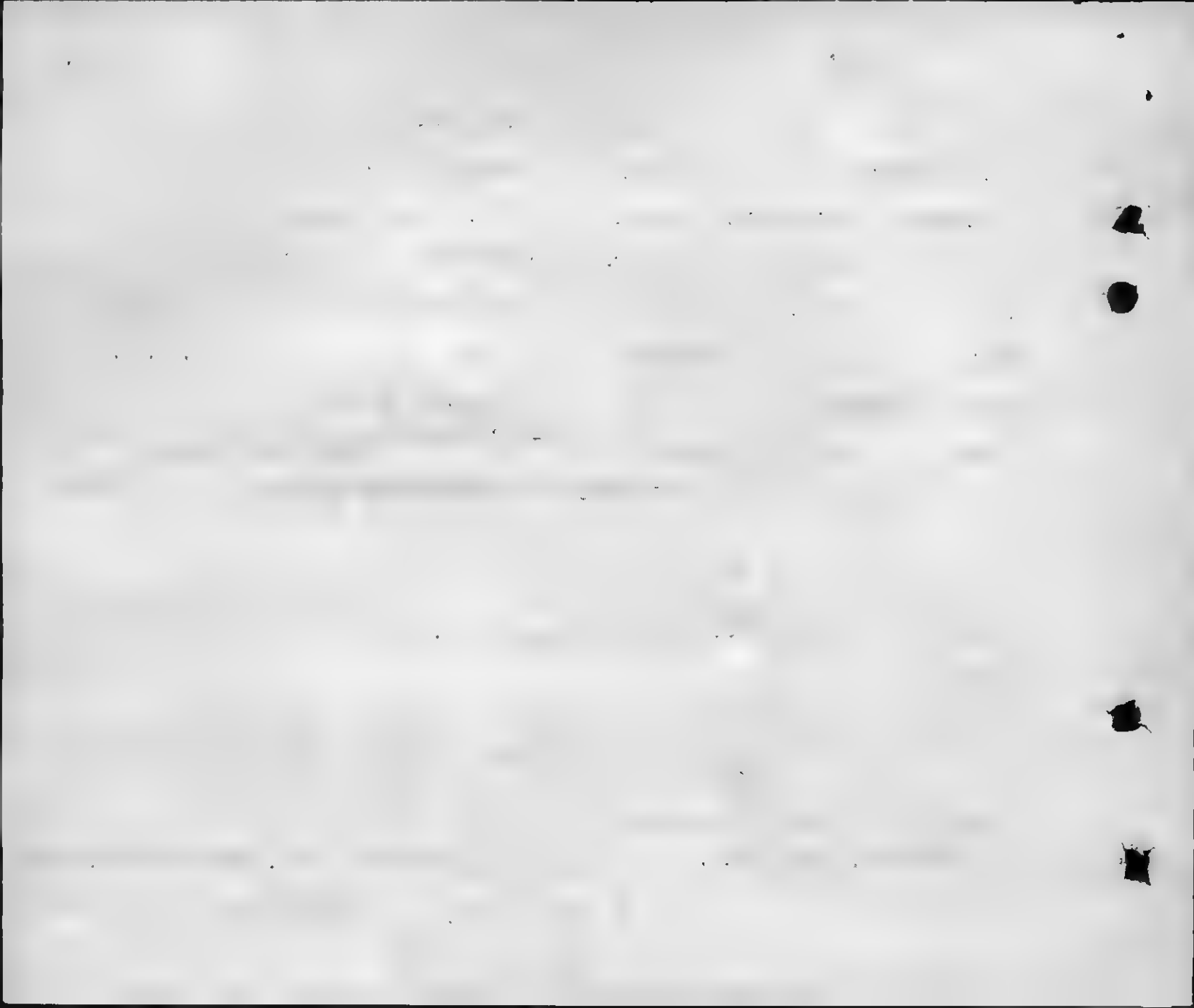
8825

CERTIFICATE OF DEATH

08818

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 97 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 d. STREET ADDRESS 5216 Tramore Avenue			
3. NAME OF DECEASED (Type or print) JOSEPH F. CORNECELLI		4. DATE OF DEATH Month August Day 8 Year 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH January 6, 1902 9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef 10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Michael Cornecelli 14. MOTHER'S MAIDEN NAME Christine Gentile			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 269-12-5182 17. FORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PAPILLARY CARCINOMA OF KIDNEY WITH METASTASES DUE TO 180X Conditions, if any, which gave rise to immediate cause (b) Found (c), stating the underlying cause last. Operation: 1/30/61 Tumor (papillary carcinoma) Rt. Kidney. Nephrectomy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
20c. TIME OF INJURY Month, Day, Year 1961 Hour a.m. 10:55 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION		20f. (City or town) Baltimore (County) Dauphin County, Pennsylvania (State) Pennsylvania			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3, 1961 , to August 8, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 8, 1961 , and that death occurred at 10:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 8/9/61		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 8-9-61			
24. FUNERAL DIRECTOR'S SIGNATURE WM COCK BLUNT INC. 6000 HARFORD RD		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery 23d. LOCATION (City, town or county) Dauphin County, Pennsylvania		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE AUG 11 '61 Arthur S. Kinn			

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital or funeral director may be relieved of this requirement if the certificate has been signed by the attending physician or funeral director. The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital or funeral director may be relieved of this requirement if the certificate has been signed by the attending physician or funeral director. The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital or funeral director may be relieved of this requirement if the certificate has been signed by the attending physician or funeral director.

VR A15 (4)
15M 9/60

8825

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08819

1. PLACE OF DEATH
a. COUNTY BALTO CO. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN TB
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1407 HUBNER AVE

2. USUAL RESIDENCE (Where deceased lived, if first time; Residence before admission)
a. STATE MD. b. COUNTY WICOMICO
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) NANTICOKE
d. STREET ADDRESS R.F.D.

3. NAME OF DECEASED (Type or print) LOIS B. COX
First Middle Last

4. DATE OF DEATH AUG 1 1961
Month Day Year

5. SEX Female 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH 7/11/98
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher Wicomico Co 10b. KIND OF BUSINESS OR INDUSTRY VA. 11. BIRTHPLACE (County & State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME GEO. F. BLOXOM 14. MOTHER'S MAIDEN NAME LAURA CLAYTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT MARVIN E. COX Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast with metastases
170X DUE TO
Conditions, if any, which gave rise to immediate cause (b) 170X
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (his/ her) attended the deceased from July 29 1961, to Aug 1 1961, that (I) (we) last saw the deceased alive on July 21 1961, and that death occurred at 2:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE John A. Nesbitt, Jr. M.D. 22b. DATE SIGNED 8-1-61
22c. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. 22d. ADDRESS 1118 Paul St. Baltimore 2, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 8/4/61 23c. NAME OF CEMETERY OR CREMATORY WICOMICO MEM. 23d. LOCATION (City, town or county) (State) SALISBURY MD.

24. FUNERAL DIRECTOR'S SIGNATURE HILL-JOHNSON ADDRESS SALISBURY MD. 25a. REC'D BY REGISTRAR AUG 7 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Harris

HE & MARY



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FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If necessary, delay may be made, but not more than 72 hours after death. This certificate is to be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. This certificate should be executed within 24 hours after death. If necessary, delay may be made, but not more than 72 hours after death. This certificate is to be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18&20 Film 295 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 110820

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>2801-1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore md</u> d. STREET ADDRESS <u>634 Howe St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u>	First Middle Last	4. DATE OF DEATH <u>8-19-1961</u>	Month Day Year
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-10-</u> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Armed Amundt</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George Creek</u>	14. MOTHER'S MAIDEN NAME <u>Daisy Spriggs</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service)	16. SOCIAL SECURITY NO. <u>Jillie Creek</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Falling into gravel pit 30 feet deep, filled with water PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from crane into gravel pit about 30 feet deep, while working at Smuch & Sons Sand & Gravel Company, and drowned</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:00</u> p.m. <u>8-19</u> 19 <u>61</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sand & Gravel Co.</u>	20f. (City or town) <u>Baltimore</u> (County) <u>Balto.</u> (State) <u>Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. G. Smith</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	22d. LOCATION (City, town, or country) <u>Armed Amundt Co</u>
23. FUNERAL DIRECTOR <u>Choy O Wilson</u>		24a. REC'D BY REGISTRAR <u>Aug 30 '61</u>	
ADDRESS <u>1000 Sunday Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION



TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

8828

18821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 19 d. STREET ADDRESS 3014 Wells Road	
3. NAME OF DECEASED (Type or print) EDGAR R. CROOP		4. DATE OF DEATH August 1 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1891	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days 69	
11. BIRTHPLACE (County & State or foreign country) Scranton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oliver Croop		14. MOTHER'S MAIDEN NAME Emma Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-05-9794	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ACUTE SUPPURATIVE PERITONITIS PERFORATIONS, GANGRENOUS BOWEL METASTATIC ADENOCARCINOMA, PERITONEUM AND LIVER PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECENT RECENT Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 28 1961 to August 1 1961 , that (we) last saw the deceased alive on August 1 1961 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 8/1/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF Aug. 4, 1961	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		25a. REC'D BY REGISTRAR AUG 3 '61	
25b. REGISTRAR'S SIGNATURE William E. Kraus		25c. ADDRESS 7922 Wise Avenue, Balto. 22, Md.	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8829

CERTIFICATE OF DEATH

118822

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN b. <u></u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4419 Furley Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. William Thomas Cullen</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-24-1875</u> 9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>86</u> yrs. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		4. DATE OF DEATH <u>August 28th 19 61</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Printer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. PLACE, County & State, or foreign country <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Cullen, Sr.</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> 16. SOCIAL SECURITY NO. <u></u>		14. MOTHER'S MAIDEN NAME <u>Mary Fliskey</u> 17. INFORMANT <u>Harry W. Cullen 4417 Furley Ave.</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year: Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>58</u> , to <u>8/28/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/28/61</u> , 19 <u>61</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Thos. E. Roach</u> M.D.		22b. DATE SIGNED <u>8/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos. E. Roach, M.D.</u>		22d. ADDRESS <u>5550 Balto Natl Pike., Balto-28-Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-31-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR <u>AUG 30 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

John W. Hall

1871

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8 & 9, telephone call - 1-800-368-6823. Date 3/22/61. cad 18823

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
d. STREET ADDRESS 420 Academy Rd

3. NAME OF DECEASED (Type or print) Rosa L. Culotta
First Middle Last
4. DATE OF DEATH Aug. 28 19 61
Month Day Year

5. SEX F. 6. COLOR OR RACE W. 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct. 18 1869
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years, test birthday) 91 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) Ret. Seamstress Belts, Clothes Co. 11. BIRTHPLACE (Country, if foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Anthony Liberto 14. MOTHER'S M maiden name Frances
Address 420

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 216-67-6132 17. INFORMANT Mrs. Frances Alagna Academy Rd
(If yes, power or dates of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) generalized arteriosclerosis
DUE TO (c) anemia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐

21. I certify that (I) (this hospital) attended the deceased from 6:30 - 41, 19 61, to 8:28, 19 61, that (I) (we) last saw the deceased alive on 7-6-61, 19 61, and that death occurred at 8:28 M, from the causes and on the date stated above.

22a. SIGNATURE Harry S. Gimbel M.D. 22b. DATE SIGNED 8/29/61
22c. PHYSICIAN'S NAME (Type) HARRY S. GIMBEL M.D. 22d. ADDRESS 4605 Ambrose Ave

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Sept. 1/61 23c. NAME OF CEMETERY OR CREMATORY New Cathedral 23d. LOCATION (City, town or county) (State) Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Wingel Phil. 4201 Edmondson Ave ADDRESS 4201 Edmondson Ave 25a. REC'D BY REGISTRAR AUG 31 '61 25b. REGISTRAR'S SIGNATURE James L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician must be present at the death. The law also requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8831 CERTIFICATE OF DEATH 118824											
Item 23 Film 6022 by 11/11/61											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Maryland							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN b 118 Days							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore 17							
3. NAME OF DECEASED (Type or print) MILTON				Last DIGGS, JR.				4. DATE OF DEATH Month August Day 9 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1915		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Coast Guard Yard				11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Milton Diggs				14. MOTHER'S MAIDEN NAME Maude Lee							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 217-05-6136				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA WITH METASTASIS TO THE 200.0 XXXX LIVER Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) 200.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200.0										INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Baltimore				20g. (County) Baltimore				20h. (State) Maryland			
21. I certify that (this hospital) attended the deceased from April 13, 1961 to August 9, 1961 , that (s) (we) last saw the deceased alive on August 9, 1961 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan											
22b. DATE SIGNED 8/9/61											
22c. PHYSICIAN NAME (Type or print) THOMAS F. CRAHAN, M.D.											
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/14/61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			
23d. LOCATION (City, town or county) Baltimore 28, Maryland				23e. REC'D BY REGISTRAR 1348 N. Calhoun St.				23f. REGISTRAR'S SIGNATURE George G. Kelson			
24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson Funeral Home Baltimore 17, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the attending physician and completed by the funeral director. After 1 certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

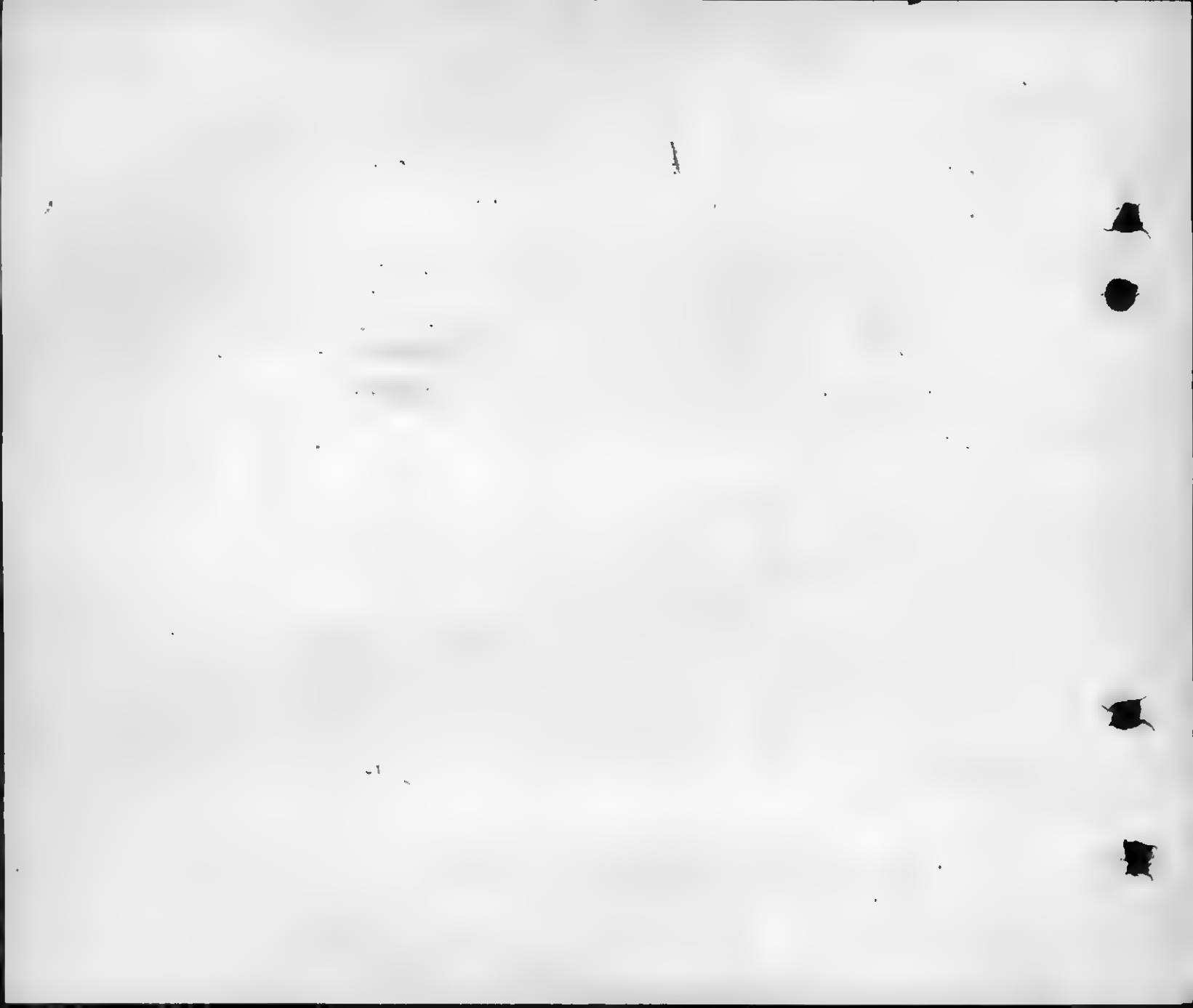
VR A15 (4)
TSM 9/59

8832

MD STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

18825

1 PLACE OF DEATH a. COUNTY MARYLAND Baltimore		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES RUSSELL DRISCOLL		4 DATE OF DEATH Aug. 1, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1901	
9. AGE (In years last birthday) 70 yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY TACK MFG.	
11. BIRTHPLACE (State and County) Allegheny Co., PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DENNIS DRISCOLL		14. MOTHER'S MARRIAGE NAME MARY AGNES SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-7940	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO <input checked="" type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO <input type="checkbox"/> (c) <input type="checkbox"/> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. Arteriosclerosis generalized			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-19-1961 to 8-1-1961 , that (I) (we) last saw the deceased alive on 8-1-1961 , and that death occurred at 2:40 PM on the causes and on the date stated above.			
22a. SIGNATURE William C. Evans M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8-1-1961			
22c. PHYSICIAN'S NAME (Type) William C. Evans, M.D., Superintendent 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF AUG 5-1961 23c. NAME OF CEMETERY OR CREMATORY ST. CEDAR HILL CEM. 23d. LOCATION (City, town, or county) (State) BROOKLYN, N.Y.			
24. FUNERAL DIRECTOR'S SIGNATURE HOWARD EVANS ADDRESS 14005 CHASE AVE. BALTO. MD. 25a. REC'D BY REGISTRAR AUG 3 '61 25b. REGISTRAR'S SIGNATURE Charles E. Evans			





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8834

08827

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Port Howard**
c. LENGTH OF STAY IN b. **89 days**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Veterans Administration Hospital**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Baltimore 17**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **1610 Harlem Avenue**
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) **WILLIAM M. DUNHAM**
First Middle Last

4. DATE OF DEATH **August 9 1961**
Month Day Year

5. SEX **Male**
6. COLOR OR RACE **Negro**
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **April 20, 1888** 73 yrs.
9. AGE (In years last birthday) **73** yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Trucking**
11. BIRTHPLACE (County & State, or foreign country) **Waterbury, Connecticut**
12. CITIZEN OF WHAT COUNTRY? **U.S.A.**
13. FATHER'S NAME **Robert Dunham**
14. MOTHER'S MAIDEN NAME **Charity Burns**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes WW-1**
16. SOCIAL SECURITY NO. **WW-1**
17. INFORMATION **Clinical Records, 3900 Loch Raven Blvd. Balto 18, Md - FORT HOWARD DIVISION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CARDIAC ARRHYTHMIA, ACUTE**
DUE TO **ARTERIOSCLEROTIC HEART DISEASE**
Conditions, if any, which gave rise to immediate cause (b) **UNKNOWN**
(a), stating the underlying cause last, (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **HYPERTENSIVE CARDIOVASCULAR DISEASE**
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
20f. (City or town) (County) (State)

21. I certify that **I** (this hospital) attended the deceased from **May 12, 1961** to **August 9, 1961**, that **I** (we) last saw the deceased alive on **August 9, 1961**, and that death occurred at **P.M.** from the causes and on the date stated above.

22a. SIGNATURE **Thomas F. Crahan**
22b. DATE **8/10/61**
22c. PHYSICIAN'S NAME (Type) **THOMAS F. CRAHAN**
22d. ADDRESS **VAH Balto 18, Md. Fort Howard Division**
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

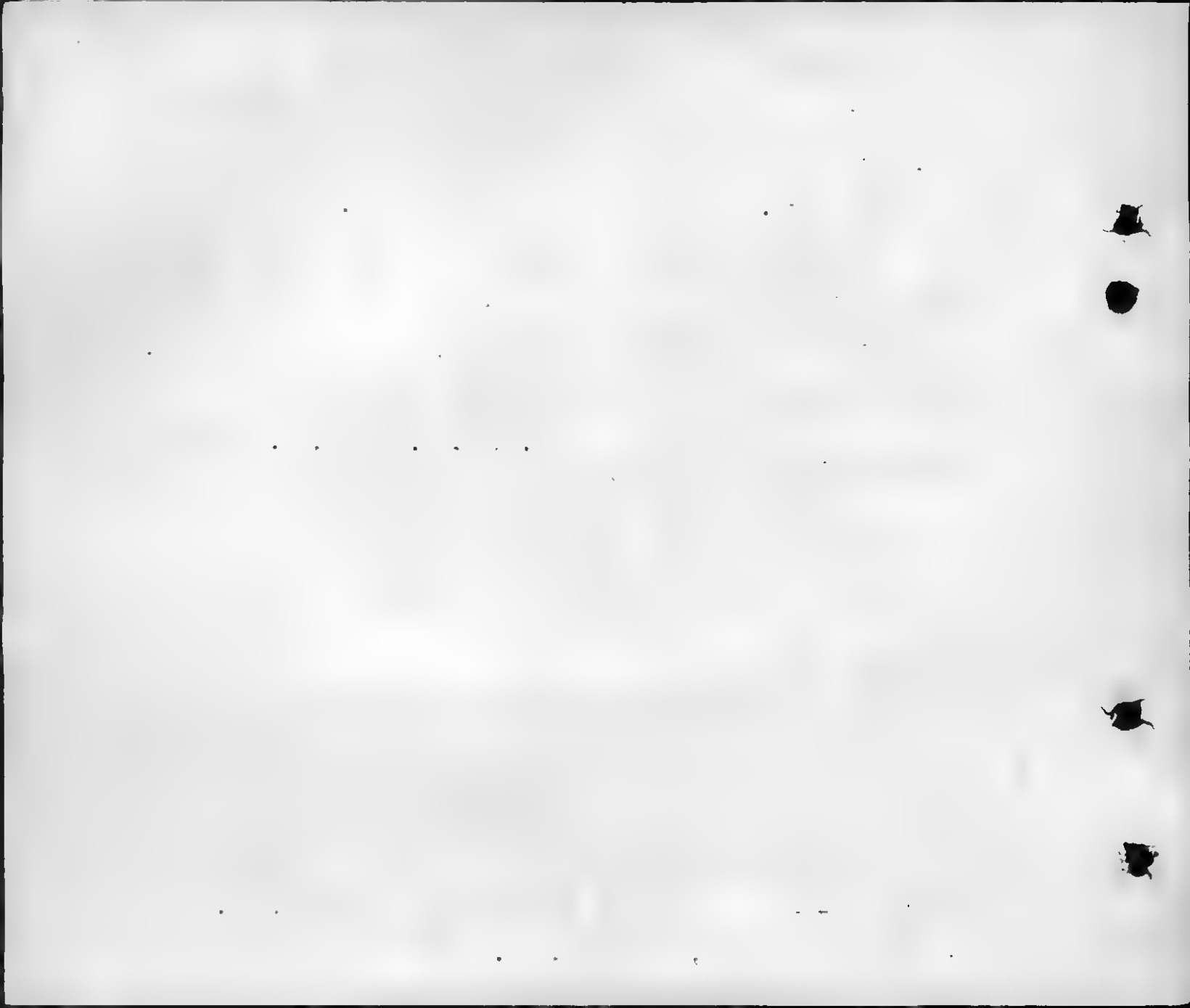
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
23b. DATE THEREOF **8-14-61**
23c. NAME OF CEMETERY OR CREMATORY **Baltimore National Cemetery**
23d. LOCATION (City, town or county) (State) **Baltimore 28, Maryland**
24. FUNERAL DIRECTOR'S SIGNATURE **Samuel W. Sullivan, Jr.**
ADDRESS **1011 N. Arlington Ave. Baltimore, Maryland**
25a. REC'D BY REGISTRAR **AUG 11 '61**
25b. REGISTRAR'S SIGNATURE **Arthur L. Hines**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician. Completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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may be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8835
CERTIFICATE OF DEATH

118829

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>5yrs 4 1/2 mon.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. STREET ADDRESS <u>3703 N. Charles St</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>EFF</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 3 1869</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert EFF</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service, <u>---</u>)		16. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT Address <u>Mrs. Cuel P. Schmidt - 3908 N. Charles St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>---</u> <u>---</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>---</u> 19 <u>61</u> to <u>present</u> 19 <u>---</u> , that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest C Brown Jr</u>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/31/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>---</u>				22d. ADDRESS <u>1101 N. Calvert St</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Gekner + Sons</u>				ADDRESS <u>Balto. 7, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 1 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

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118



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician. Complete by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician. Complete by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN 1b **12 Days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **18**
d. STREET ADDRESS **762 Exeter Hall Avenue**

3. NAME OF DECEASED (Type or print) **DEWEY**
First Middle Last
DEWEY **ESAIAS**

4. DATE OF DEATH **August 28**
Month Day Year
August 28 **1961**

5. SEX **Male**
6. COLOR OR RACE **White**
7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **May 5, 1898**
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) **63** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Custodian**
10b. KIND OF BUSINESS OR INDUSTRY **Public Building**
11. BIRTHPLACE (County & State or foreign country) **Morris Run, Pennsylvania**
12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Richard Esaias**
14. MOTHER'S MAIDEN NAME **Jane Jones**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** **WW II** **579-03-7706**
16. SOCIAL SECURITY NO. **579-03-7706**
17. INFORMANT **Clinical Records, VAH, Baltimore** Address **18, Md. Ft. Howard**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CEREBROVASCULAR ACCIDENT**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **ARTERIOSCLEROTIC HEART DISEASE**
DUE TO (c) **UNKNOWN**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) **diabetes Mellitus**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **August 16, 1961** to **August 28, 1961**, that ☒ (we) last saw the deceased alive on **August 28, 1961** and that death occurred at **1:30** M, from the causes and on the date stated above.

22a. SIGNATURE **Thomas F. Crahan**
22b. PHYSICIAN'S NAME (Type) **THOMAS F. CRAHAN, M.D.**
22c. ADDRESS **VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION**
22d. DATE SIGNED **8/28/61**

23a. REC'D BY REGISTRAR **25a. REC'D BY REGISTRAR**
23b. DATE THEREOF **8/31/61**
23c. NAME OF CEMETERY OR CREMATORY **Baltimore National Cemetery**
23d. LOCATION (City, town or county) (State) **Baltimore 28, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Ellsworth Amacost**
25a. REC'D BY REGISTRAR **25b. REGISTRAR'S SIGNATURE**
25c. ADDRESS **4600 Liberty Hgts.**
25d. DATE **AUG 29 '61**

VR A15 (4)

15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completed after the funeral director has been signed by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed after the funeral director has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, fill in pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

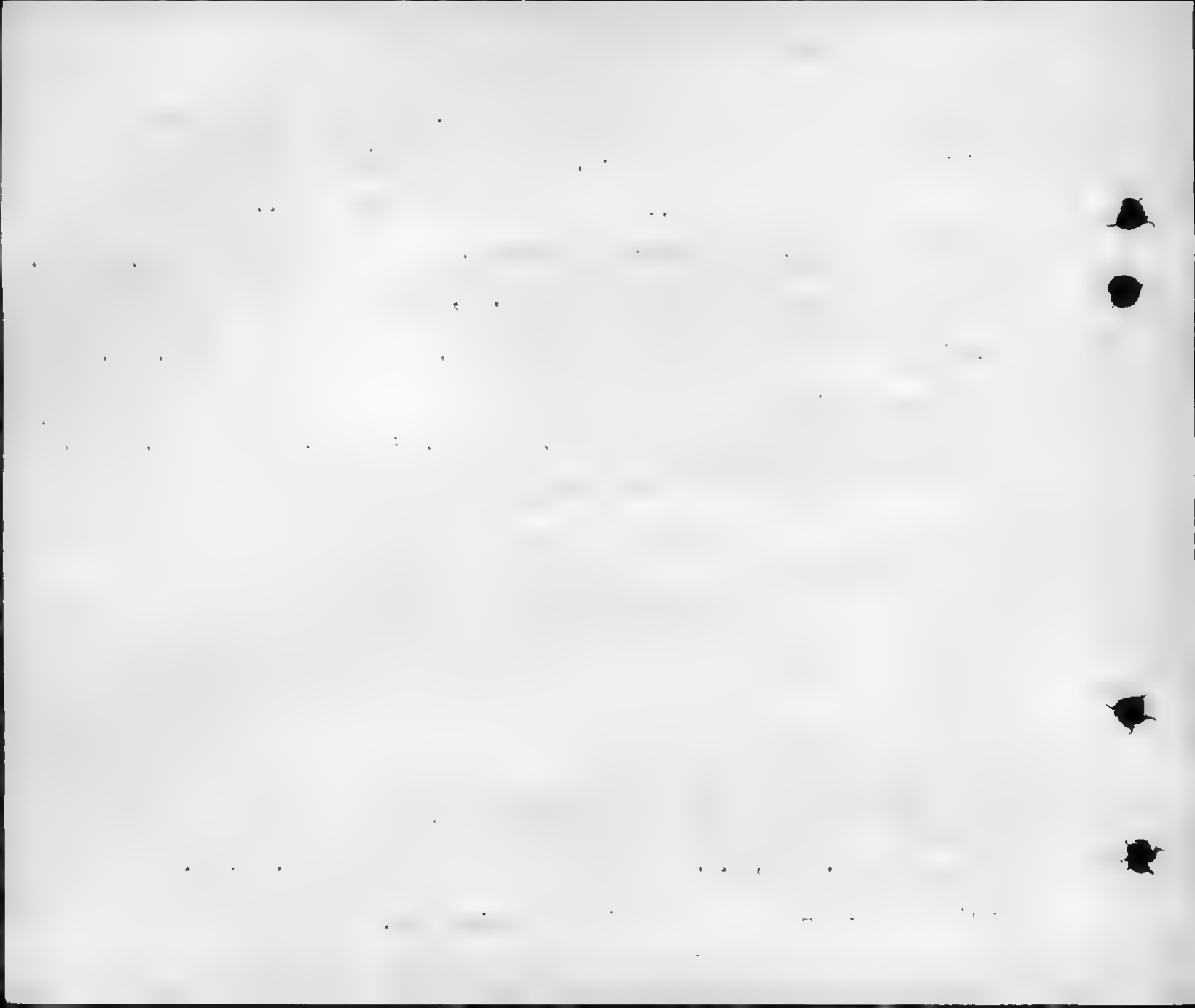
VR A15 (4)
15M 9/59

8838

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118831

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 734 Edmondson Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Winfield Last Etzler		4. DATE OF DEATH Month August Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1893
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Etzler		14. MOTHER'S MAIDEN NAME ? Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. George D. Etzler		Address 3615 Yolando Rd. Balto. 18, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 mo 4 mo		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/27, 1961 to 8/24, 1961 , that (I) (we) last saw the deceased alive on 8/24, 1961 , and that death occurred on 8/24, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE James E. Rowe		22b. DATE SIGNED 8/25/61	
22c. PHYSICIAN'S NAME (Type) James E. Rowe, M.D.		22d. ADDRESS 1011 Frederick Rd. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-28-1961	
23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Eastman and Rowe		25a. REC'D BY REGISTRAR DATE SET '61	
25b. REGISTRAR'S SIGNATURE Carroll Co., Maryland			



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 18832

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u> c. LENGTH OF STAY IN TB <u>10 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>308 OVERBROOK RD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u> d. STREET ADDRESS <u>308 OVERBROOK RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY LOUISE FAIRBANKS</u>		4. DATE OF DEATH <u>AUG. 4 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (in years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. BRITCHER</u>		14. MOTHER'S MAIDEN NAME <u>LEONARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. MARY EGER, 308 OVERBROOK RD</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>TIMOTHY BALTIMORE</u>		DATE SIGNED <u>8-4-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-8-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		22d. LOCATION (City, town, or country) <u>BALTO.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR <u>H-W-JENKINS & SONS Co. 4905 YORK RD</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>AUG 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



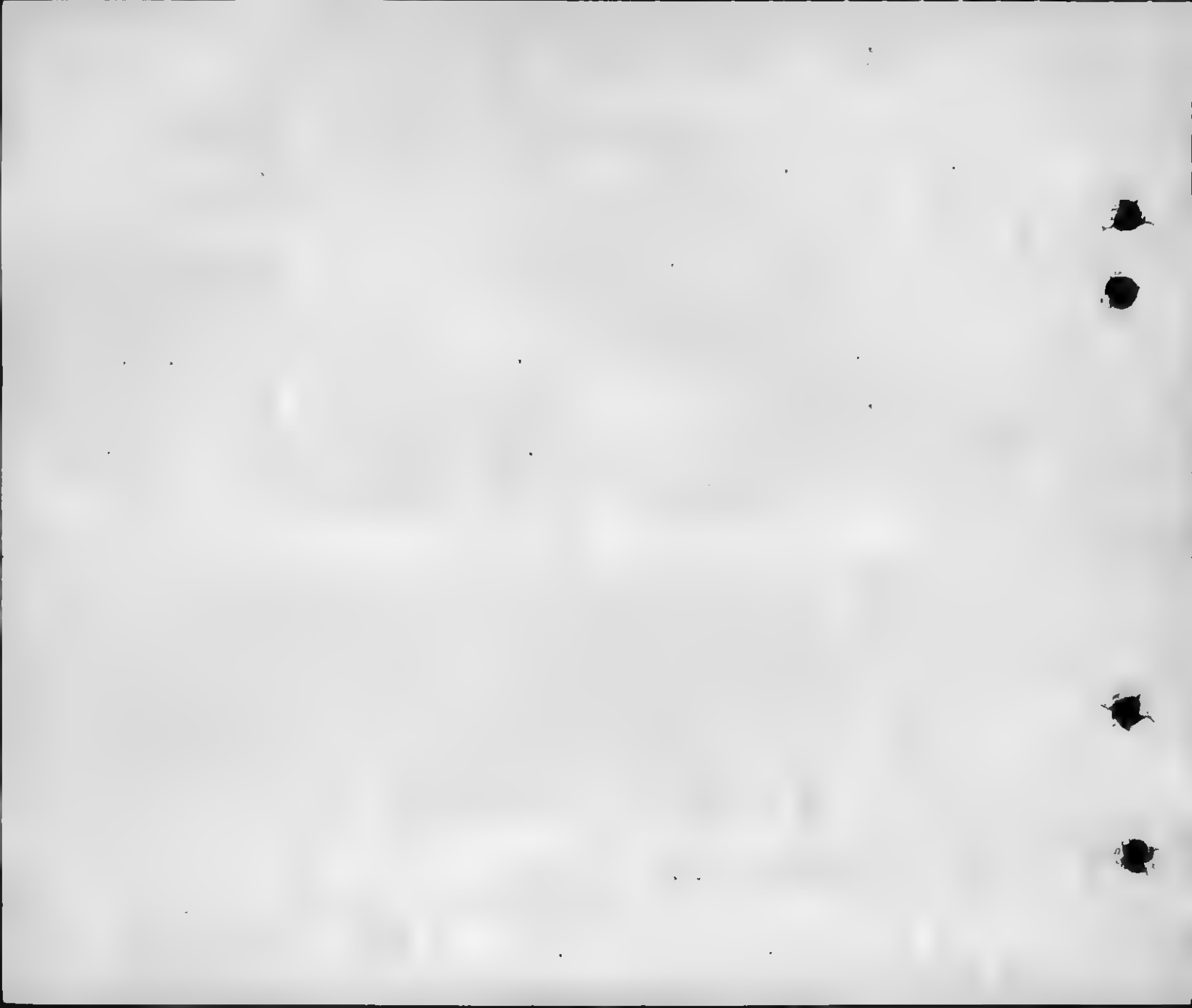
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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 24 hours after the death of the decedent. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death. The certificate should be executed in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
EM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 18833											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore, Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4216 Lynhurst Road						e. STREET ADDRESS 4216 Lynhurst Road					
3. NAME OF DECEASED (Type or print) LAWRENCE J. FERSTERMAN						4. DATE OF DEATH Month August Day 30 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 3, 1904		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 1 Hours 0 M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker-retired						11. BIRTHPLACE (State or foreign country) Maryland					
13. FATHER'S NAME George C. Fersterman						14. MOTHER'S MAIDEN NAME Fredericka Kodel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.						16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Beatrice Clewis, 1506 Rosewick Ave-6,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Cerebral Occlusion						INTERVAL BETWEEN ONSET AND DEATH 1 hr					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Jack Collins						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Jack Collins, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) 831-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/1/61		22c. NAME OF CEMETERY OR CREMATORY Zion Evan. Lutheran Cem.				22d. LOCATION (City, town, or county) (State) Stemmers Run, Md.	
23. FUNERAL DIRECTOR Ulrich Funeral Home, 4210 Belair Road.						24a. REC'D BY REGISTRAR DATE SEP 5 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08854											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1mthldys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1424 W. Pratt Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Fannie S. Fim					4. DATE OF DEATH Month August Day 2 Year 1961						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1884		9. AGE (In years last birthday) 76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) restaunt worker					10b. KIND OF BUSINESS OR INDUSTRY Penna.		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Robert Sherwood					14. MOTHER'S MAIDEN NAME Laura Meyers					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown					16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arterioscl. Cardio Vasc. Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis, generalized, severe											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Amputation to lower third of left thigh due to gangrene of left foot										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 12, 1961 to 8/2, 1961 , that (I) (we) last saw the deceased alive on 8/2, 1961 , and that death occurred at 3 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslor M.D.					22b. DATE SIGNED 8/2/61		22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8/5/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Crest		23d. LOCATION (City, town or county) (State) Trucksville, Pa.		
24. FUNERAL DIRECTOR'S SIGNATURE K. R. WILLIAMS					ADDRESS Lynchburg, Pa.		25a. REC'D BY REGISTRAR AUG 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8842

CERTIFICATE OF DEATH

Reg. Dist. No.

118835

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b 104 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1049 MARLAU DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES E FITZPATRICK SR. First Middle Last		4. DATE OF DEATH AUG 14 1961 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 24-1884 9. AGE (In years last birthday) 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MATTHEW J FITZPATRICK		14. MOTHER'S MAIDEN NAME MARGARET TINNAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-03-9660 17. INFORMANT ELSIE M. FITZPATRICK BALTIMORE Address 818 W 34th St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute & Chronic Congestive Heart Failure DUE TO Feilur 2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/14/61	20f. (City or town) (County) (State) 8/14/61
21. I certify that I attended the deceased from 8/14/61 , 19 61 , to 8/14/61 , 19 61 , that I last saw the deceased alive on 8/14/61 , 19 61 , and that death occurred at 1010 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Mc Grath PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville, Md DATE SIGNED 8/17/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-18-61	22c. NAME OF CEMETERY OR CREMATORY WOODLAWN	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE Frank A Seitz ADDRESS 814 W 36th St BALTO. MD		24a. REC'D BY REGISTRAR AUG 18 '61 24b. REGISTRAR'S SIGNATURE William J. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8843

CERTIFICATE OF DEATH

08856

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>55 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 29</u> d. STREET ADDRESS <u>4606 Manordene Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>P</u> Last <u>FORNOFF</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>19 61</u>		5. SEX <u>Male</u> 6. CO. OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>March 21, 1898</u> 9. AGE (In years last birthday) <u>63</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS									
Months	Days	Hours	Min.								
13. FATHER'S NAME <u>William Fornoff</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Haddaway</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>216-10-4420</u> 17. INFORMANT <u>Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md - FORT HOWARD DIVISION</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u> DUE TO (b) <u>SEVERE MYOCARDIAL FIBROSIS</u> DUE TO (c) <u>SEVERE CORONARY STENOSIS AND SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>1. Chronic obstructive hypertrophic emphysema</u> <u>2. Chronic cholecystitis - cholelithiasis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 12, 1961</u> to <u>August 6, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 6, 1961</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Sebastian Russo</u> M.D. 22b. DATE SIGNED <u>8/7/61</u> 22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u> 22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-10-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck & Sons, Inc. 5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR <u>AUG 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained in the hospital or attending physician's office for 4 years after death. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. It is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, adding the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VS. A15ME
5M 9/60

Items 18-21 Film 295
8-30-61
M

18-21 Film 295
8-30-61
M

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Forest (21)**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Marlyn Avenue Bridge**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **D. C.**
b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Washington**
d. STREET ADDRESS **5120 Sargent Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)
First **MATHIAS** Middle **FRANCIS** Last **FORST**

4. DATE OF DEATH
Month **August** Day **4** Year **19 61**

5. SEX **Male**
6. COLOR OR RACE **White**
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **Dec. 3, 1902**
9. AGE (In years last birthday) **58/59** yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Administrative hospital**
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) **Wisconsin**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **George Forst**
14. MOTHER'S MAIDEN NAME **?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **Yes W1**
16. SOCIAL SECURITY NO. **577-40-5732**
17. INFORMANT **Winnifred Forst** Address **Same**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Drowning**
975X
Conditions, if any, which gave rise to immediate cause (b) **?**
(c), stating the underlying cause last. **?**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **?**

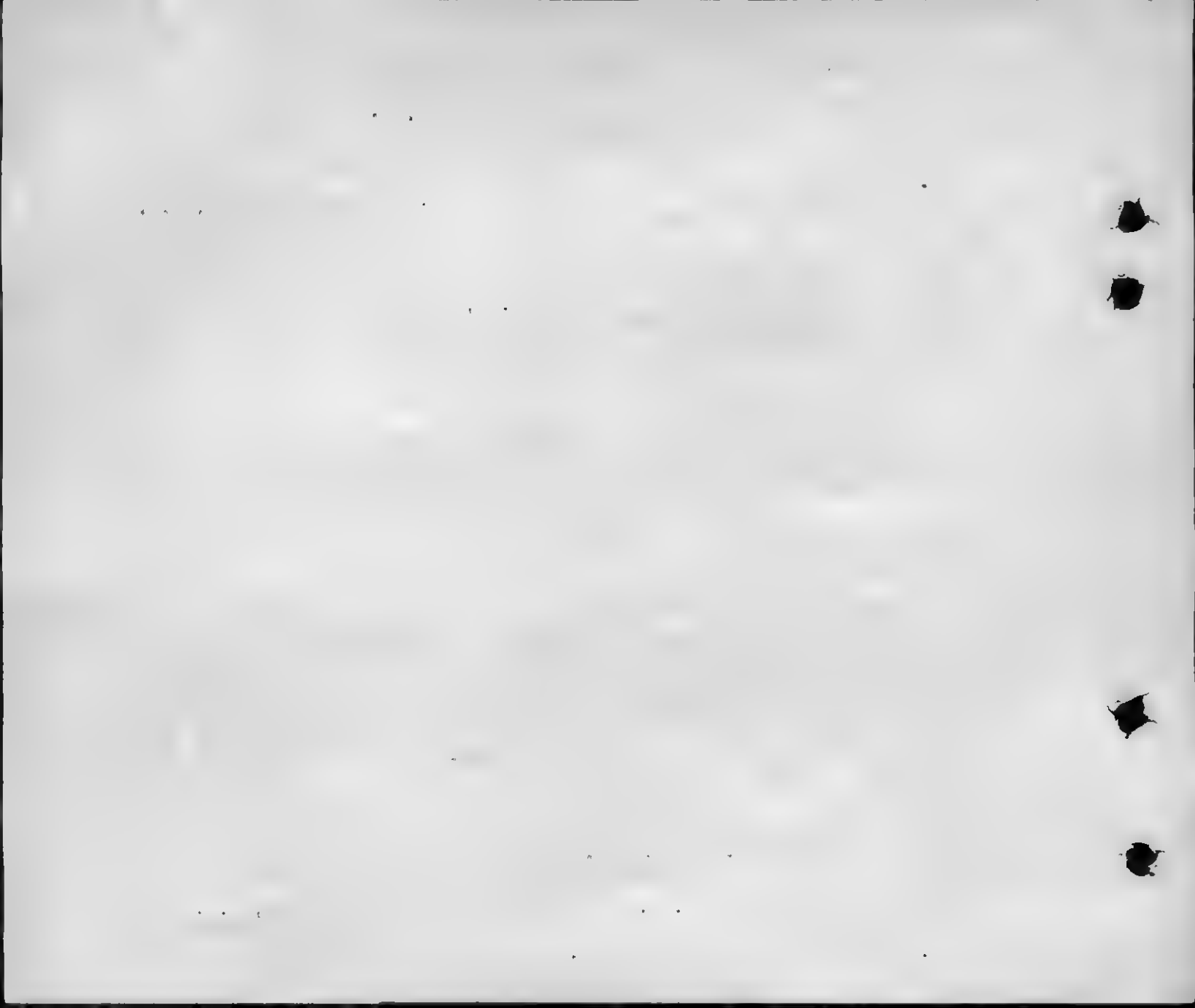
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) **Found drowned**
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. **Unknown 19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Water**
20f. (City or town) **Balto.** (County) **Md.** (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Howard G. Shaub** M.D.
EXAMINER'S NAME (Type) **Howard G. Shaub, M.D.**
22a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**
22b. DATE THEREOF **8/4/61**
22c. NAME OF CEMETERY OR CREMATORY **S. I. Hines Funeral Home**
22d. LOCATION (City, town, or country) **Washington, D.C.** (State)

23. FUNERAL DIRECTOR **James H. Pruski** ADDRESS **7407 Eastern Ave.**
24a. REC'D BY REGISTRAR **7 '61**
24b. REGISTRAR'S SIGNATURE **Arthur L. Kraus**

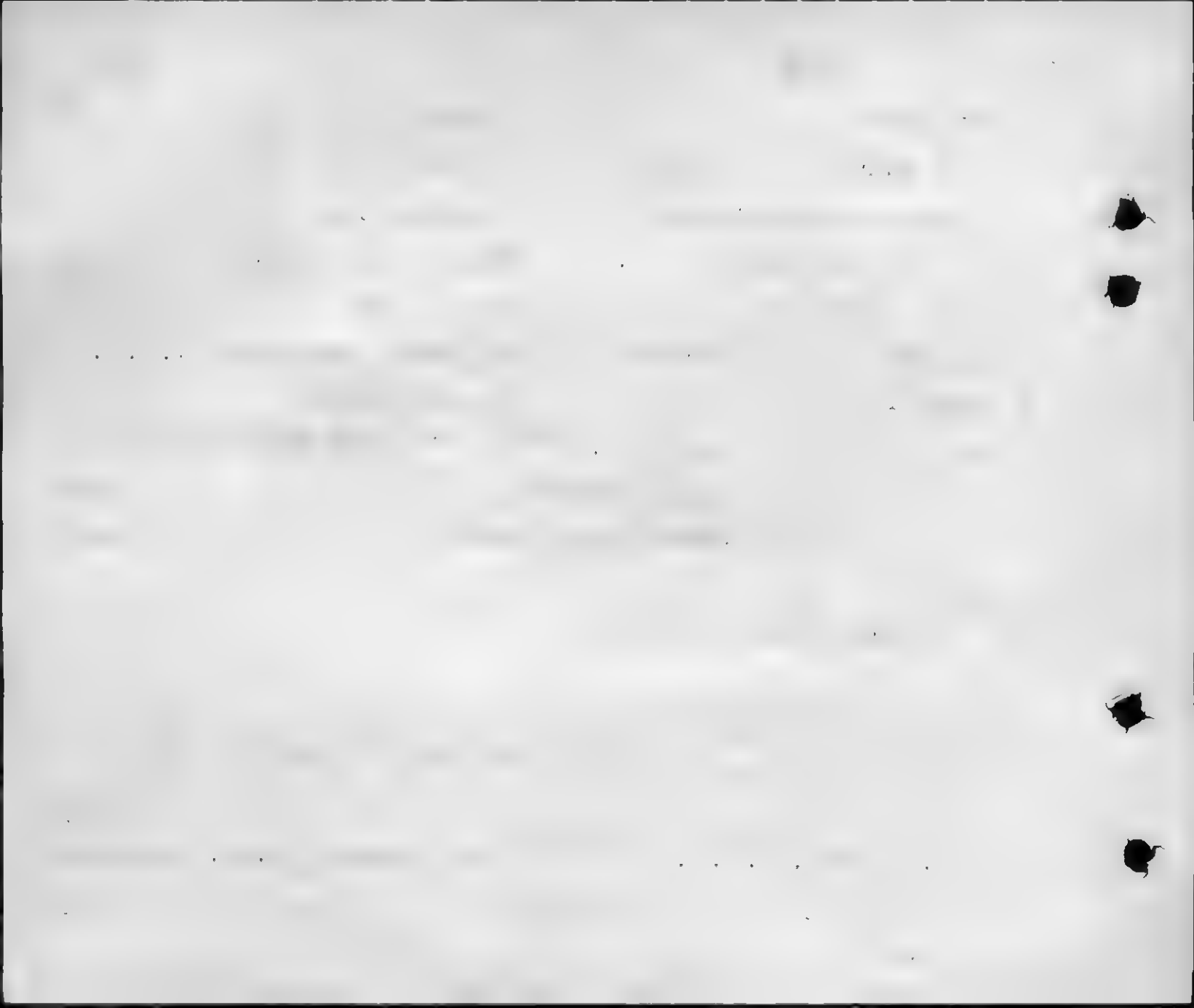


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician. It must be signed by the attending physician and completed in by the funeral director. To FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8845 CERTIFICATE OF DEATH 08838											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 12 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 843 Eutaw Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First GORDON		Middle B.		Last FREY		4. DATE OF DEATH Month August		Day 4	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 7, 1889		9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 19 Days 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker				10b. KIND OF BUSINESS OR INDUSTRY Trucking				11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John B. Frey							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO WW I 218-18-1254				17. INFORMANT Elizabeth Griffith			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO 332X Conditions, if any, which gave rise to immediate cause (b) CEREBRAL ARTERIOSCLEROSIS [c], stating the underlying cause last, (c) UNKNOWN											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Baltimore				20g. (County) Baltimore				20h. (State) Maryland			
21. I certify that (this hospital) attended the deceased from July 23, 1961 to August 4, 1961 , that (we) last saw the deceased alive on August 4, 1961 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE R. H. Robertson, Jr.				22b. DATE SIGNED 8/4/61				22c. PHYSICIAN'S NAME (Type) R. H. ROBERTSON, JR. M. D.			
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 7, 61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) Baltimore				23e. (State) 28, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc., North & Penna. Aves. Baltimore Md.				25a. REC'D BY REGISTRAR AUG 7 61				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			
DATE AUG 8 '61											



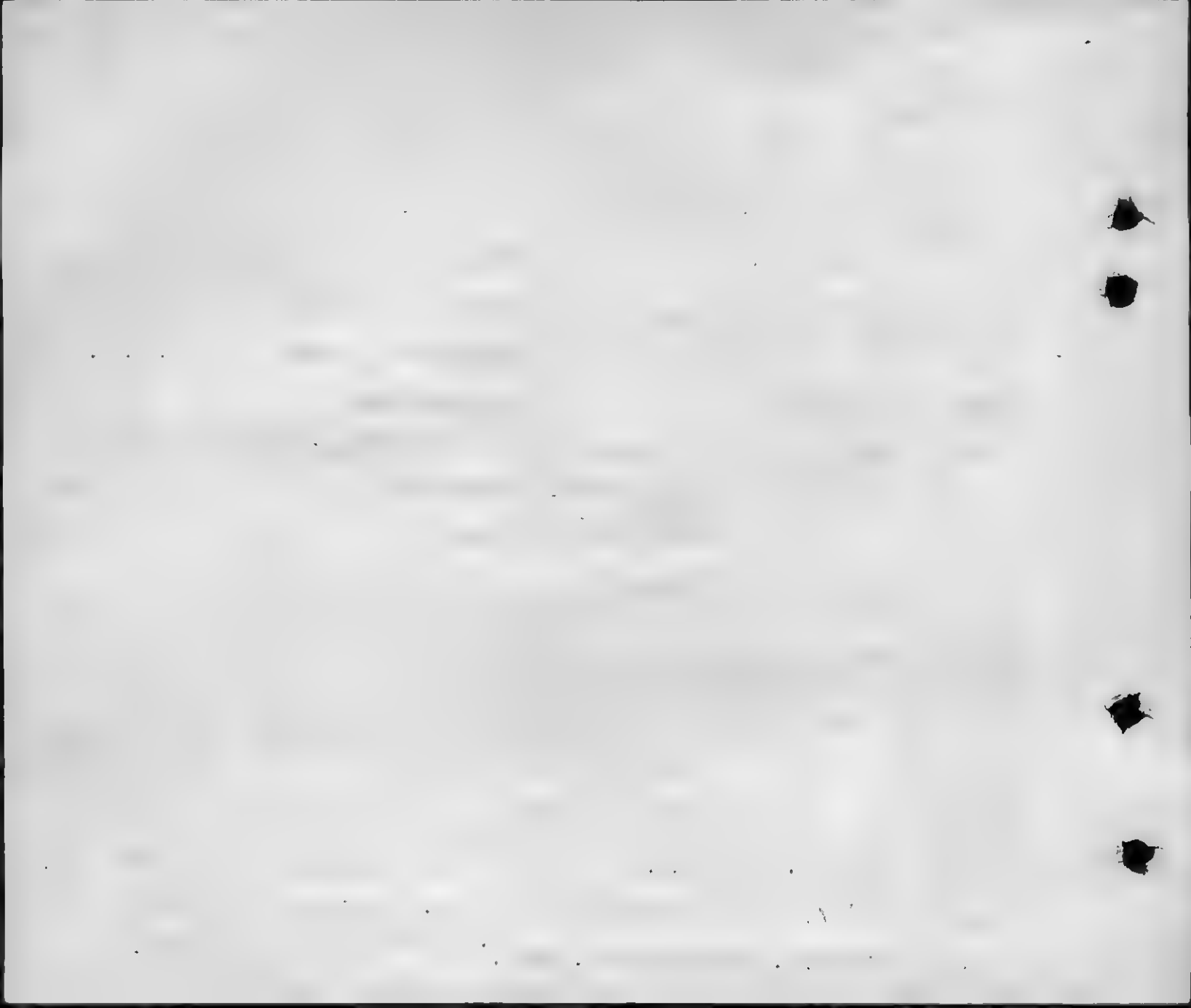
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08859

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 60 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3612 Frankford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last WALTER J GIBBONS			4. DATE OF DEATH Month Day Year August 14 19 61		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1891 December 24, 1890		
9. AGE (in years last birthday) 70 69 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Robert Lee Gibbons			14. MOTHER'S MAIDEN NAME De Maria Blades		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I			16. SOCIAL SECURITY NO. None		
17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OLD SUB-ARACHNOID HEMORRHAGE DUE TO (b) FRACTURE OF SKULL CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) TERMINAL BRONCHOPNEUMONIA PYELONEPHRITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 3 DAYS - / - -		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Fell down steps at home			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at home		
20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. 6/13/ 19 61			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore			20f. (City or town) (County) (State) Baltimore Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> M.B. Davis M.D. ACTUAL SIGNATURE EXAMINER'S NAME (Type) MELVIN B. DAVIS, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/2 8/14/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8-17-61		
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			22d. LOCATION (City, town, or country) (State) Baltimore 28, Maryland		
23. FUNERAL DIRECTOR Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14			24a. REGISTRY REC. STAMP Aug 21 61		
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			24c. REGISTRAR'S SIGNATURE		

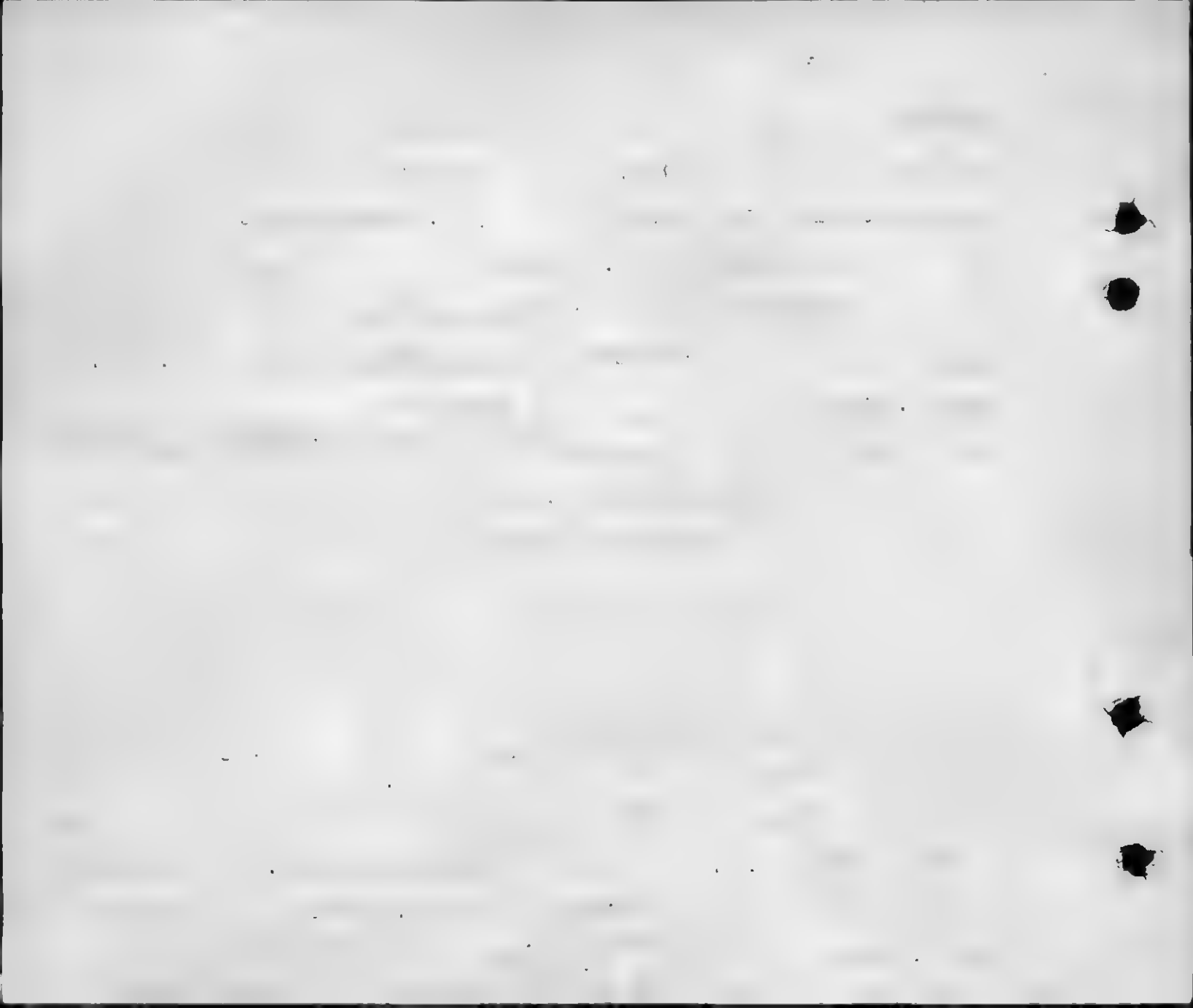
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8847

Arthur L. Kane

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VR A15 (4)
15M 9/59

1
8848
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
118841

1 PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
c. LENGTH OF STAY IN 1b <u>5 weeks</u>				d. STREET ADDRESS <u>1334 Poplar Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1334 Poplar Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie L. Golden</u>				4. DATE OF DEATH Month Day Year <u>August 29 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1877</u>	
9. AGE (In years lost birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
13. FATHER'S NAME <u>William Fisse</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Ammenheuser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1334 Poplar Ave</u>			
17. INFORMANT Address <u>Mrs. George Corisrin 1334 Poplar Ave</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u>				(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <u>8/21 1961</u> to <u>8/29 1961</u> , that (I) (we) last saw the deceased alive on <u>8/29 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert J. Levickas</u>				22d. ADDRESS <u>5305 East Drive</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery Baltimore Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Amelrose, Inc. 1328 Sulphur Sp. Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. Thur S. Hume</u>	

62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8849

118842

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY N 1b 10yr8mth24dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1000 Bentalou Street	
3. NAME OF DECEASED (Type or print) Alice Annie Goll		4. DATE OF DEATH Month August Day 25 Year 19 61	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1871	
9. AGE (In years last birthday) 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Lett		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Terminal pneumonia 4433X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Senile brain disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 31, 1950 to Aug. 25, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 25, 1961 , and that death occurred at 6:15 A. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar			
22b. DATE SIGNED 8-25-61			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.			
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 8/28/61			
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			
23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Emmanuel B. Brown			
25a. REGISTRAR'S SIGNATURE Wm. S. Evans			
25b. REGISTRAR'S SIGNATURE Wm. S. Evans			
25c. DATE 10 2 9 '61			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8850

118843

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Granite</i>		c. LENGTH OF STAY IN 1b <i>about 8 or 6 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Granite</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Paul Ave</i>				d. STREET ADDRESS <i>St. Paul Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Joseph</i> Last <i>Gosnell</i>				4. DATE OF DEATH Month <i>August</i> Day <i>27</i> Year <i>19 61</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 12, 1910</i>	9. AGE (In years last birthday) <i>50</i> yrs.	IF UNDER 1 YEAR Months <i>50</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Myerhoff Lumber Co</i>		11. BIRTHPLACE (State or foreign country) <i>Granite</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Eugene E. Gosnell</i>				14. MOTHER'S MAIDEN NAME <i>Agnes L. Greenwalt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>no.</i>		16. SOCIAL SECURITY NO. <i>215-10-9985</i>		17. INFORMANT <i>Mrs. Eugene L. Gosnell</i> Address <i>St. Paul Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Heart</i> DUE TO (c) <i>Heart</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1010 Leeds Ave</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 1010 Leeds Ave ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Geo. S. M. KIEFFER, M.D.</i>				DATE <i>Aug 28, 61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>August 30, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring B. Brown</i>				24a. REC'D BY REGISTRAR <i>Aug 30 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

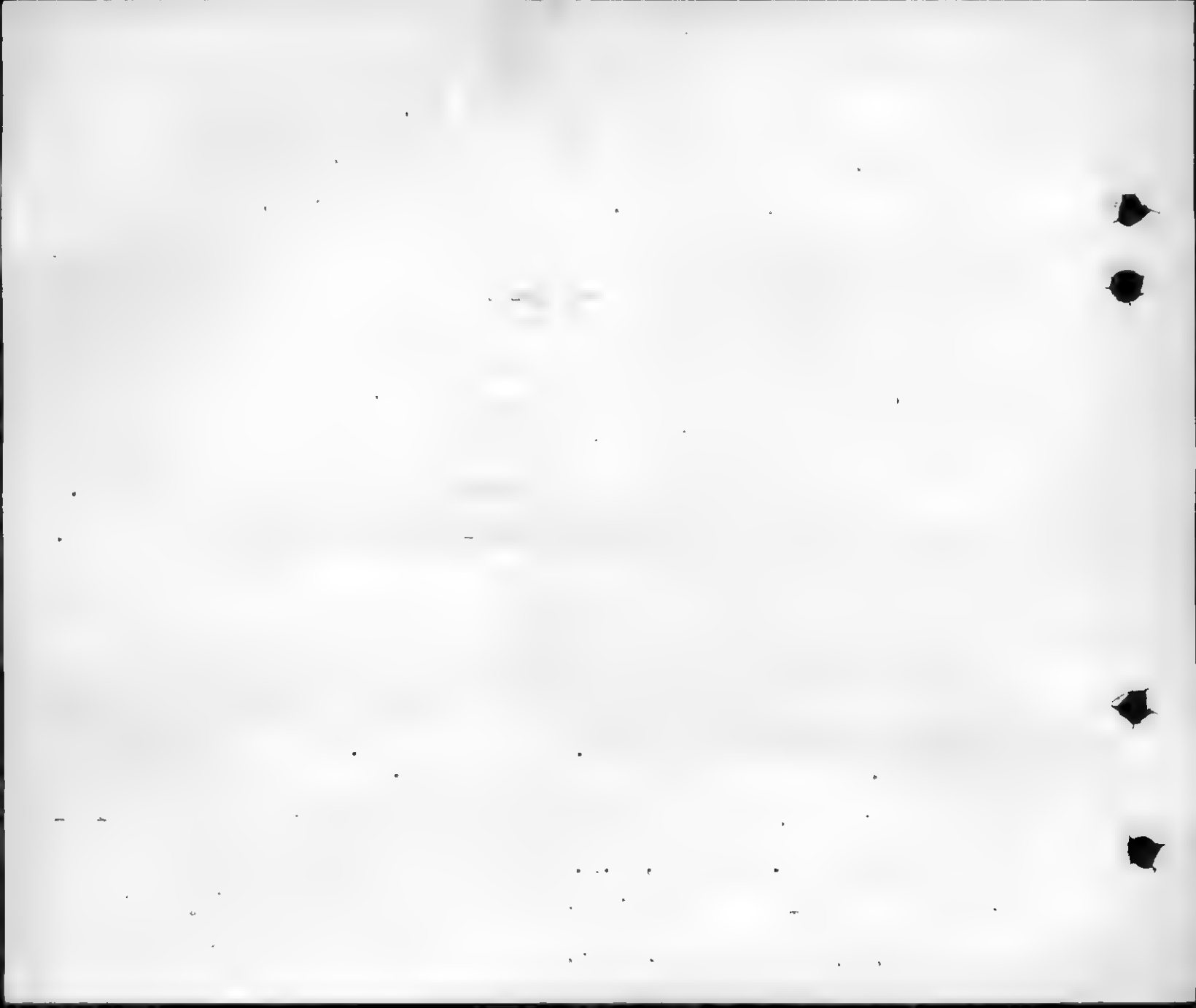
CERTIFICATE OF DEATH

Reg. Dist. No. 08844

8851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tollgate, Owens Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tollgate Rd. Owens Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 Tollgate Rd.</u>		d. STREET ADDRESS <u>201 Tollgate Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary Alice</u> Middle <u>Green</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>19 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1911</u>
9. AGE (In years last birthday) yrs. <u>49</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leo J. Downey</u>		14. MOTHER'S MAIDEN NAME <u>Alice E. Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212249098</u>	
INFORMANT <u>Mrs Louise Collins</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2</u> hr. <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 20</u> , 19 <u>61</u> , to <u>Aug. 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug. 20</u> , 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 Main Street</u> DATE SIGNED <u>8-21-61</u>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		M.D. <u>Reisterstown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>9-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

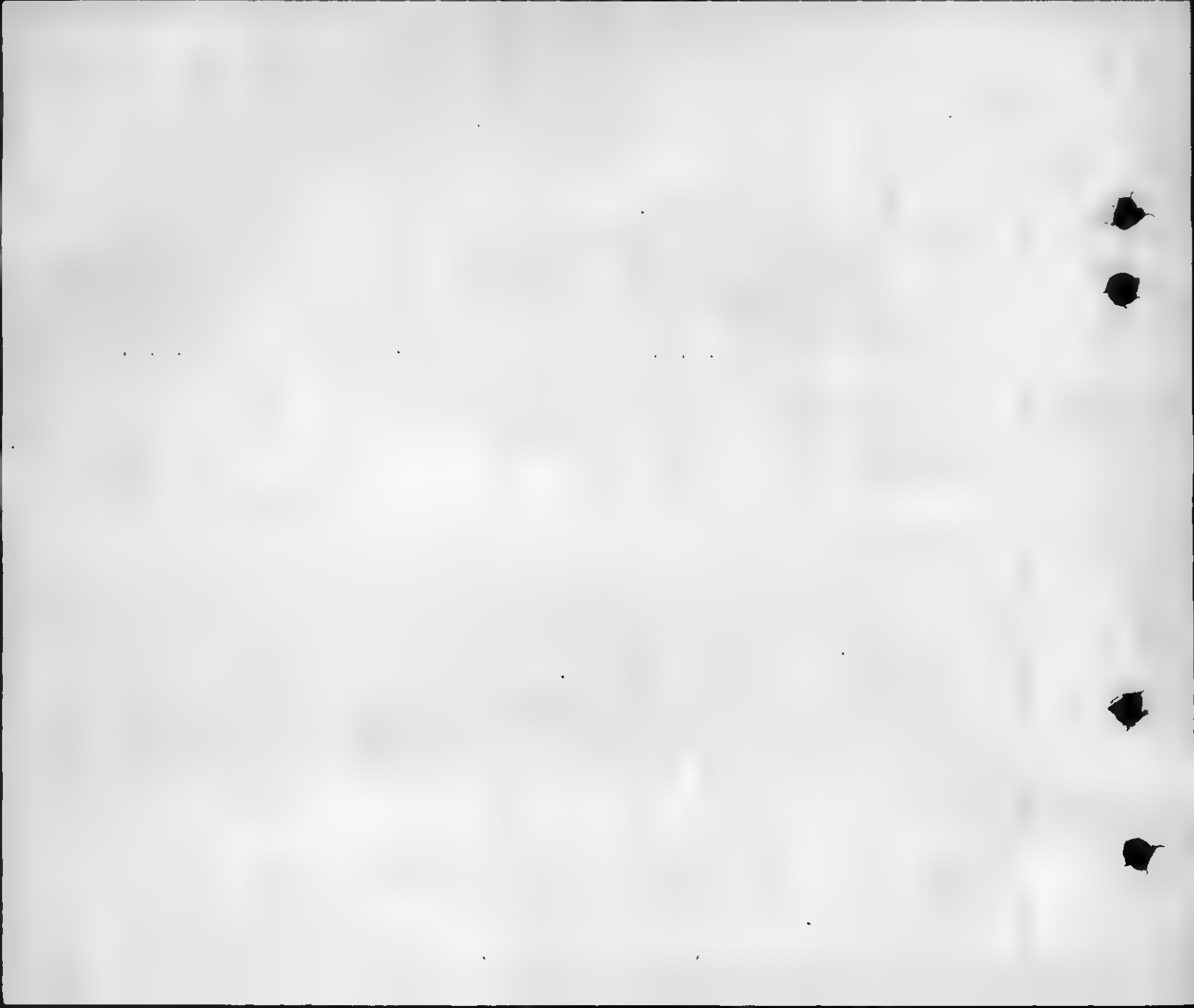
8852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18845

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN TB 1 WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3605 NORTH POINT BLVD.				d. STREET ADDRESS 1008 BAYLIS STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHAINA Middle ELEANOR Last GURN				4. DATE OF DEATH Month AUGUST Day 15 , Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 17, 1886	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS RETIRED		10b. KIND OF BUSINESS OR INDUSTRY B.V.D. CORP.		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME FREDERICK GURN			
14. MOTHER'S MAIDEN NAME CAROLINE BAGER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. 212 10 5218				17. INFORMANT Address Mrs Eleanor Cox 3605 North Point Blvd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS MD				DATE SIGNED 8/16/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 17, 1961		22c. NAME OF CEMETERY OR CREMATORY FIRST EVANGELICAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE 17 61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



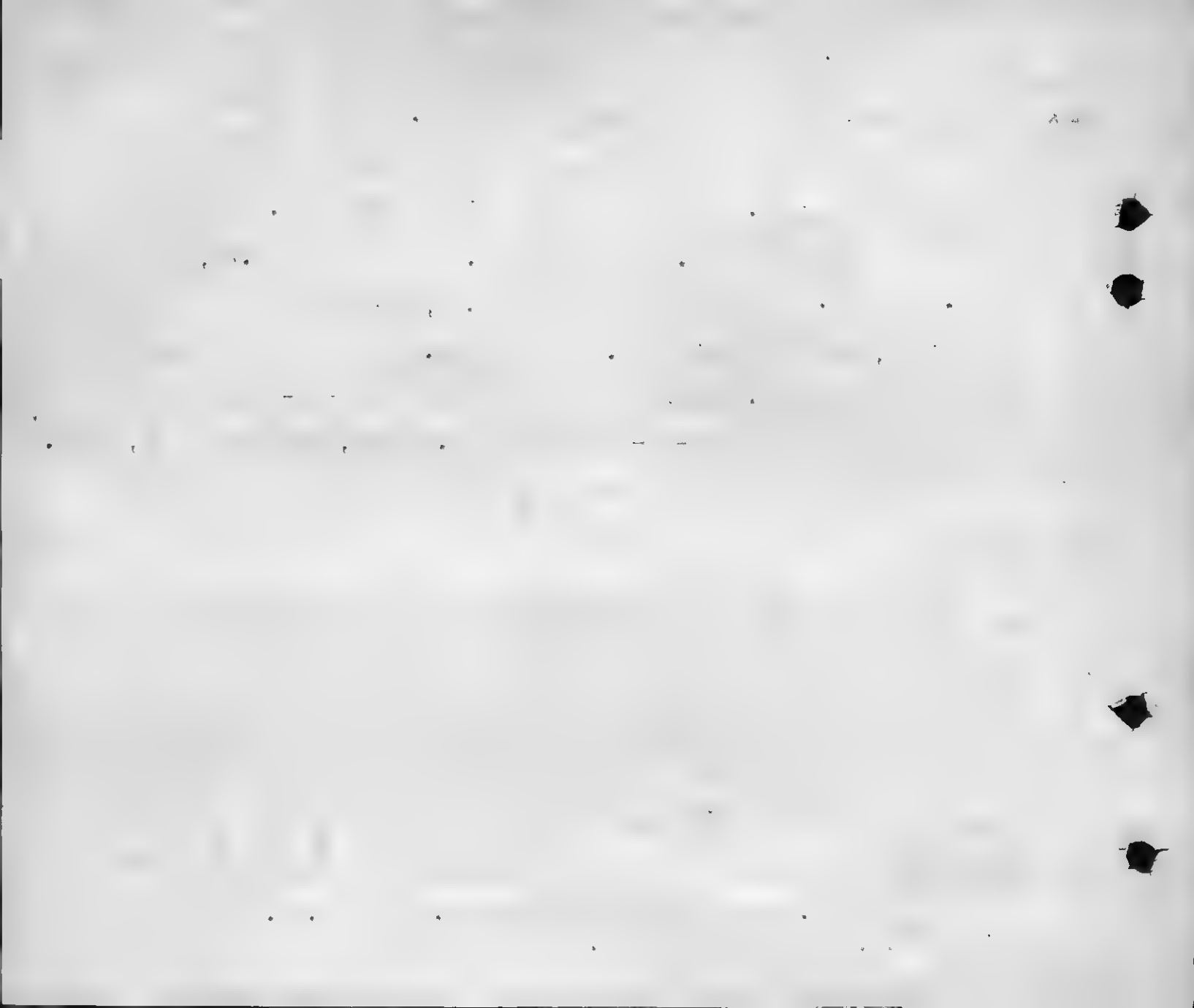
1
FOR STATE
HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																															
8853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																															
Item 9, Form G-1, 7-0-61, C.C.																															
08846																															
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE				Md.		b. COUNTY		Baltimore																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Woodlawn		c. LENGTH OF STAY in 1b		Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Woodlawn		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1832 Colmar Rd.		d. STREET ADDRESS		1832 Colmar Rd.		4. DATE OF DEATH				Month		Day		Year															
3. NAME OF DECEASED (Type or print)		Harry W. Hammel Sr.		5. SEX		M.		6. COLOR OR RACE		W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		Sept. 19, 1894		9. AGE (In years less birthday)		67 yrs.		IF UNDER 1 YEAR		Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Retired, Food Chemical Corp.		10b. KIND OF BUSINESS OR INDUSTRY		Md.		11. BIRTHPLACE (State or foreign country)		Md.		12. CITIZEN OF WHAT COUNTRY?		USA																	
13. FATHER'S NAME		William F. Hammel		14. MOTHER'S MAIDEN NAME		Mae																									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		215-03-2793		17. INFORMANT		Thelma V. Hammel		Address		Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		420.1		DUE TO		Boironay Thrombosis		Cerebral vascular disease		INTERVAL BETWEEN ONSET AND DEATH																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		GEO. S. M. KIEFFER MD		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		Address (Street, city, town, or county)		1010 Lechman		DATE SIGNED		Aug 19 1961													
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		Sept. 1/61		22c. NAME OF CEMETERY OR CREMATORY		Loudon Park Cmty.		22d. LOCATION (City, town, or country)		Balto. Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE													
23. FUNERAL DIRECTOR		Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR		AUG 31 '61		24b. REGISTRAR'S SIGNATURE		Wm. S. Thoms																					



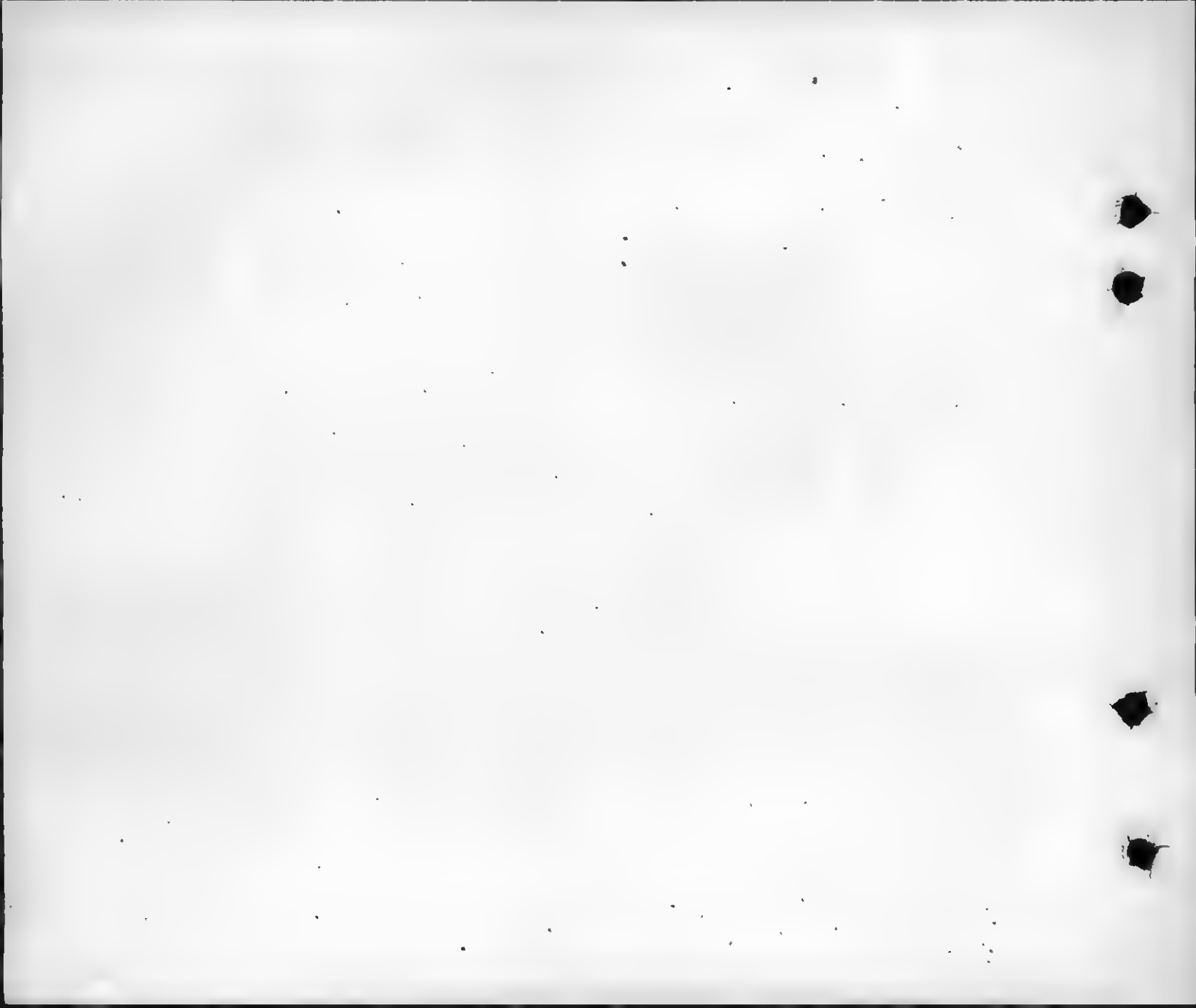
CERTIFICATE OF DEATH

Reg. Dist. No. 118847

8854

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE VA. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCHEARN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HUGSBURG Home		d. STREET ADDRESS 2959 Verdum Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE F. HANGER		4. DATE OF DEATH Month Day Year AUG. 27. 1961	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY VA.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME FRANKLIN CALBREATH.		14. MOTHER'S MAIDEN NAME FANNIE HANEY.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. RECORDS 6811 CAMPFIELD RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Sclerotic Heart Disease			
DUE TO (b) (2)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1961 to Aug 26, 1961 , that I last saw the deceased alive on Aug 25, 1961 , and that death occurred at 10:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers M.D.		ADDRESS (Street, city or town, state) 4108 Liberty Hts Balto Md 8-27-61	
PHYSICIAN'S NAME (Type) Earl L. Chambers.		DATE 4108 Liberty Hts Balto. Md	
22a. BURIAL, CREMAT ON, OR OTHER DISPOSAL (Specify) BURIAL		22b. DATE THEREOF 8/30/61	
22c. NAME OF CEMETERY OR CREMATORY Beth. Lu. Cem.		22d. LOCATION (City, town, or county) (State) Waynesboro VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Ubbemann		24a. REC'D BY REGISTRAR Aug 29 '61	
ADDRESS 6067 Harford Rd Md		24b. REGISTRAR'S SIGNATURE William S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for use as the attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8855

98848

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 44 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 d. STREET ADDRESS 4803 Arabia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
3. NAME OF DECEASED (Type or print) GEORGE A. HARRIS		4. DATE OF DEATH Month August Day 25 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 17, 1889		9. AGE (In years last birthday) 72 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.								
IF UNDER 1 YEAR		IF UNDER 24 HRS.																											
Months	Days	Hours	Min.																										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Finisher				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.																					
13. FATHER'S NAME Frank Harris						14. MOTHER'S MAIDEN NAME Mary Slick																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I						16. SOCIAL SECURITY NO 215-03-7911						17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td colspan="4"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO </td> <td colspan="2"> INTERVAL BETWEEN ONSET AND DEATH 1-1/2 HRS. </td> </tr> <tr> <td colspan="4"> Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO </td> <td colspan="2"> YEARS </td> </tr> <tr> <td colspan="4"> (c) stating the underlying cause last. ARTERIOSCLEROSIS </td> <td colspan="2"> YEARS </td> </tr> </table>												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1-1/2 HRS.		Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO				YEARS		(c) stating the underlying cause last. ARTERIOSCLEROSIS				YEARS	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1-1/2 HRS.																									
Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO				YEARS																									
(c) stating the underlying cause last. ARTERIOSCLEROSIS				YEARS																									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right CVA with Left Hemiparesis, Old Healed Infarct of Myocardium																													
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____																													
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 12, 1961 , to August 25, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 25, 1961 , and that death occurred at 3:28 P.M. from the causes and on the date stated above.																													
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) MERLE J. HAMPLER M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division																							
22b. DATE SIGNED 8-25-61																													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/29/61		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CEMETERY		23d. LOCATION (City, town or county) BALTIMORE MARYLAND																					
24. FUNERAL DIRECTOR'S SIGNATURE Wm J Tickner & Sons Inc						25a. REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur L. Hines																							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8856

08849

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Towson**
c. LENGTH OF STAY IN b **8 Mos.**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **804 Stags Head Rd.**
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Towson**
d. STREET ADDRESS **804 Stags Head Rd.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print)
First **BRICE** Middle **O.** Last **HARTER**
4. DATE OF DEATH Month **Aug.** Day **18, 1961** Year **19**
5. SEX **Male** **6. COLOR OR RACE** **White** **7. MARRIED** ☒ **NEVER MARRIED** ☐
8. DATE OF BIRTH **Sept. 11, 1893** **9. AGE** (In years last birthday) **67** yrs. **10. IF UNDER 1 YEAR** Months **18** Days **19** Hours **19** Min.

11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Construction, Air Fields - Construction**
11b. KIND OF BUSINESS OR INDUSTRY **Pennsylvania**
11. BIRTHPLACE (County & State, or foreign country) **USA**
12. CITIZEN OF WHAT COUNTRY? **USA**
13. FATHER'S NAME **Harry Harter**
14. MOTHER'S MAIDEN NAME **Lillian Orwig**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes**
16. SOCIAL SECURITY NO **None**
17. INFORMANT **Mrs. Carl F. Schunemann**
Address **804 Stags Head Rd. Towson, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Cerebro-vascular Hemorrhage**
42211 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **Congestive Heart Failure**
DUE TO **ASCVD**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Repeated C.V.A.'s**
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
INTERVAL BETWEEN ONSET AND DEATH **12 days**
1 yr
10+ yrs

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. **19** p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

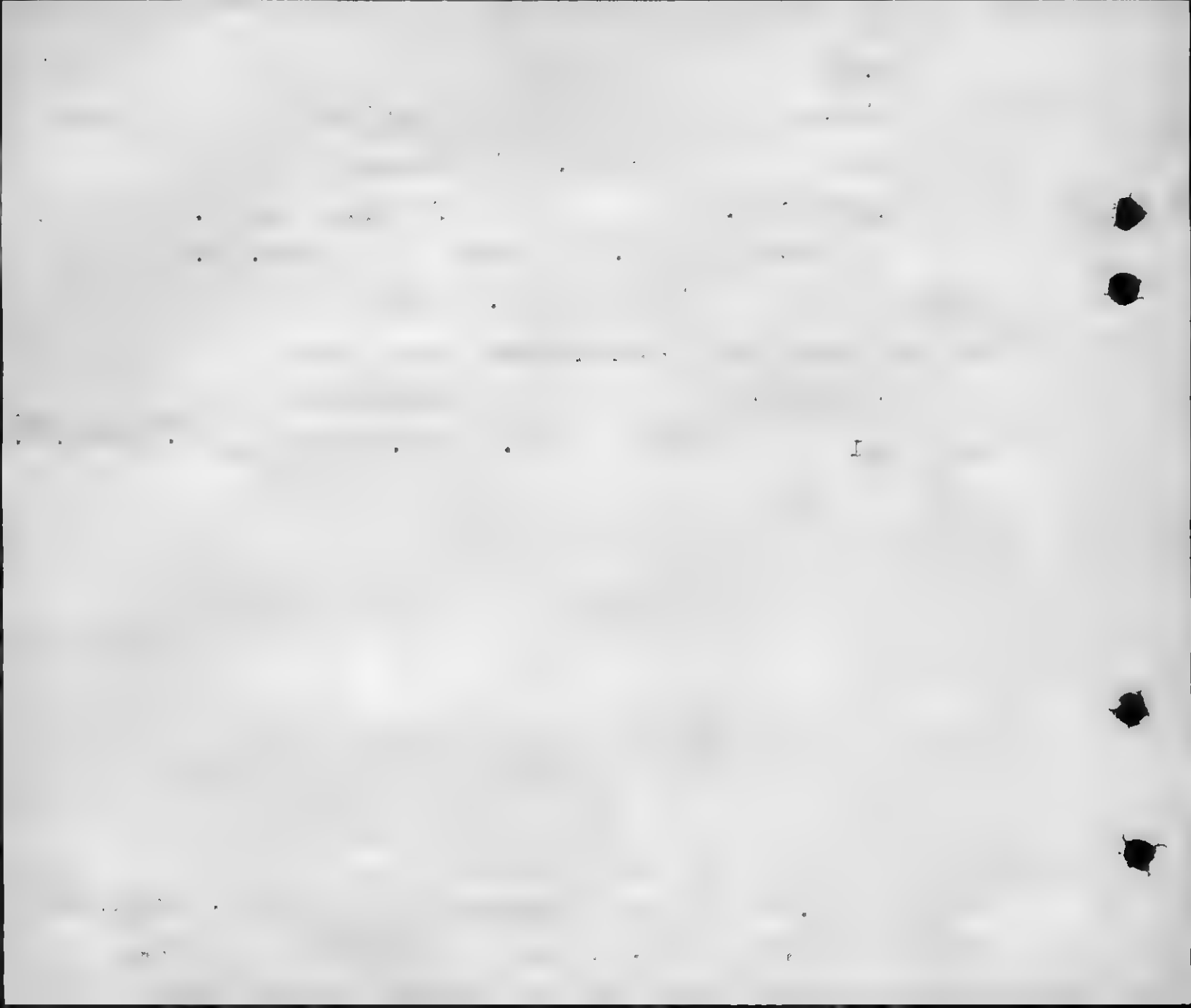
21. I certify that (I) (this hospital) attended the deceased from 10/10, 1960 to 8/18, 1961 that (I) saw the deceased alive on 8/18, 1961, and that death occurred at 9 P.M. from the causes and on the date stated above
22a. SIGNATURE **Victor J. King**
22b. DATE **8/18/61**
22c. PHYSICIAN'S NAME (Type) **M.D.**
22d. ADDRESS **ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. SIGNED**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
23b. DATE THEREOF **Aug. 22, 1961**
23c. NAME OF CEMETERY OR CREMATORY **Mifflinburg Cem**
23d. LOCATION (City, town or county) **Mifflinburg, Pennsylvania**
24. FUNERAL DIRECTOR'S SIGNATURE **Wm Cook-Towson, Inc Towson, Maryland**
25a. REC'D BY REGISTRAR **AUG 22 '61**
25b. REGISTRAR'S SIGNATURE **Arthur S. Hume**

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. The law also requires that the attending physician at the hospital or attending physician at the funeral home be retained by the funeral director. The funeral director, after this certificate has been signed by the attending physician at the hospital or attending physician at the funeral home, must file it with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I



CERTIFICATE OF DEATH

Reg. Dist. No.

08850

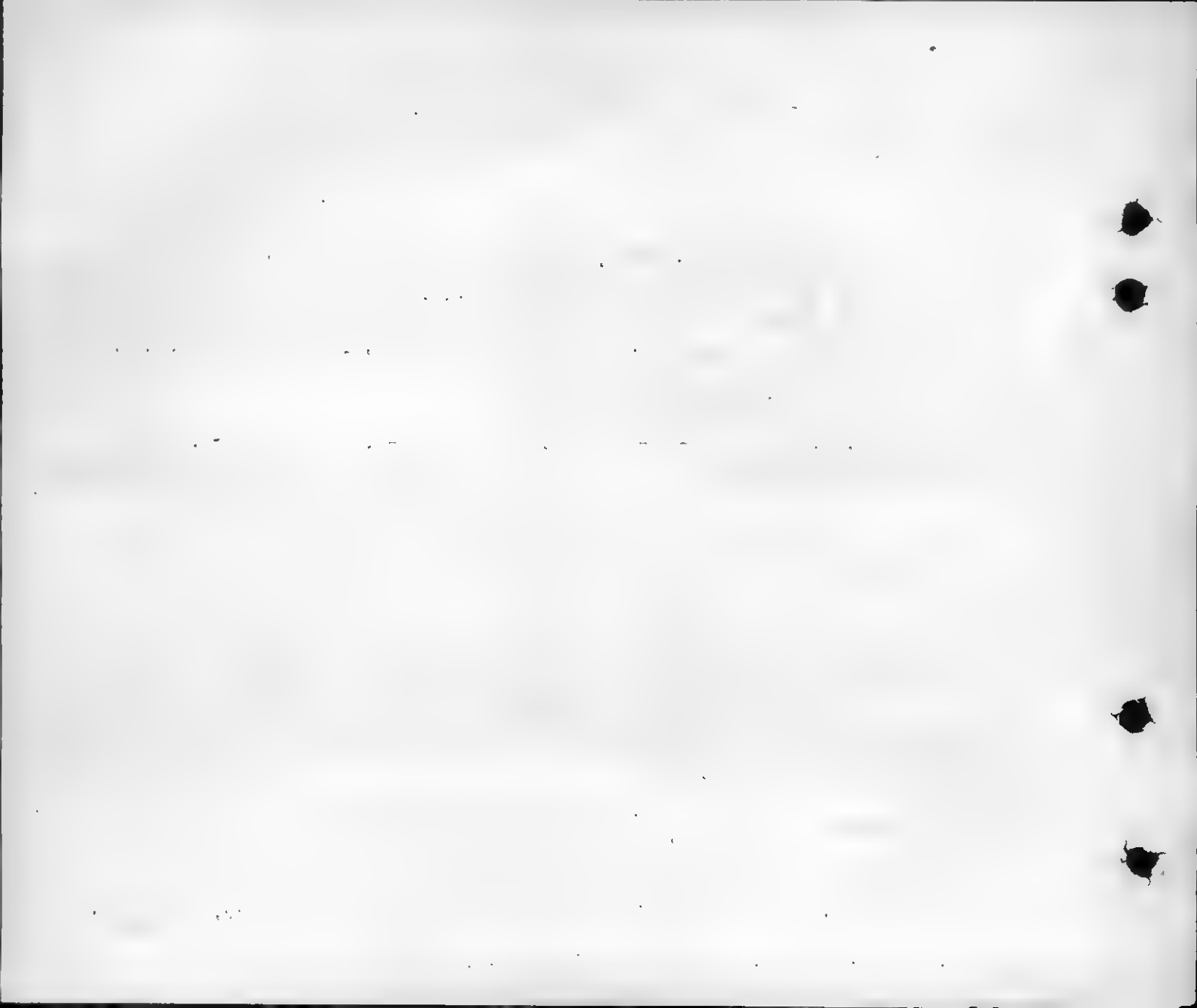
8857

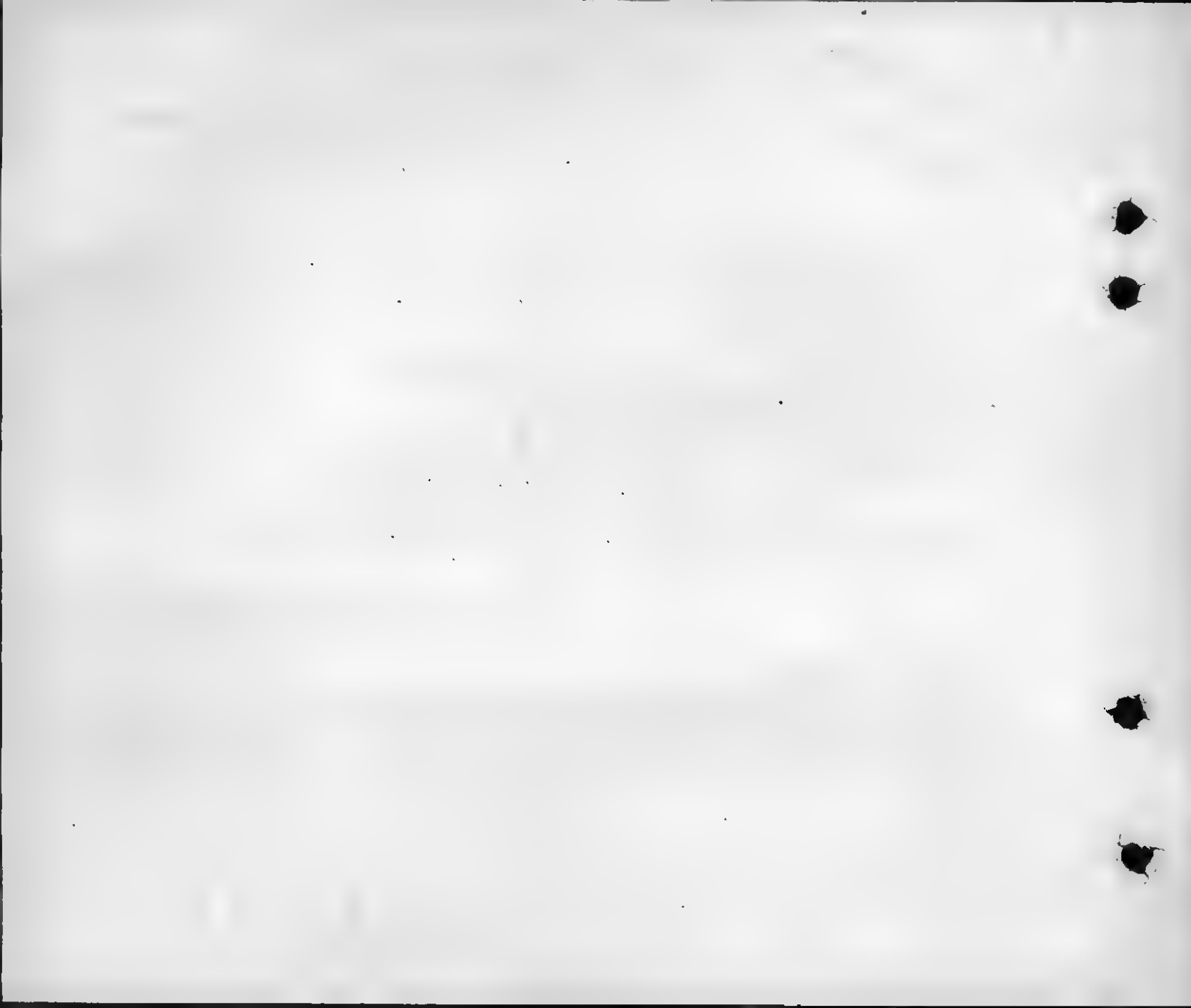
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6513 Lehnert Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sudler Middle R. Hartge Last				4. DATE OF DEATH Month August Day 17 Year 1961			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 19, 1911	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Auto Disxtributor		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry F. Hartge				14. MOTHER'S MAIDEN NAME Bessie Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11 213-10-3651		INFORMANT Irene Hartge-6513 Lehnert St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF AORTIC ANEURYSM twix DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPTEMBER, 1957 to AUGUST 17, 1961 , that I last saw the deceased alive on AUGUST 15, 1961 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel Blumenfeld		M.D. 2104 Gaym Oak Ave. Balto Md		ADDRESS (Street, city or town, state) 2104 Gaym Oak Ave. Balto Md		DATE SIGNED 8-17-61	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS 4600 Liberty Heights Ave.		24a. REC'D BY REGISTRAR DATE AUG 18 '61	
				24b. REGISTRAR'S SIGNATURE Ellsworth Armacost			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

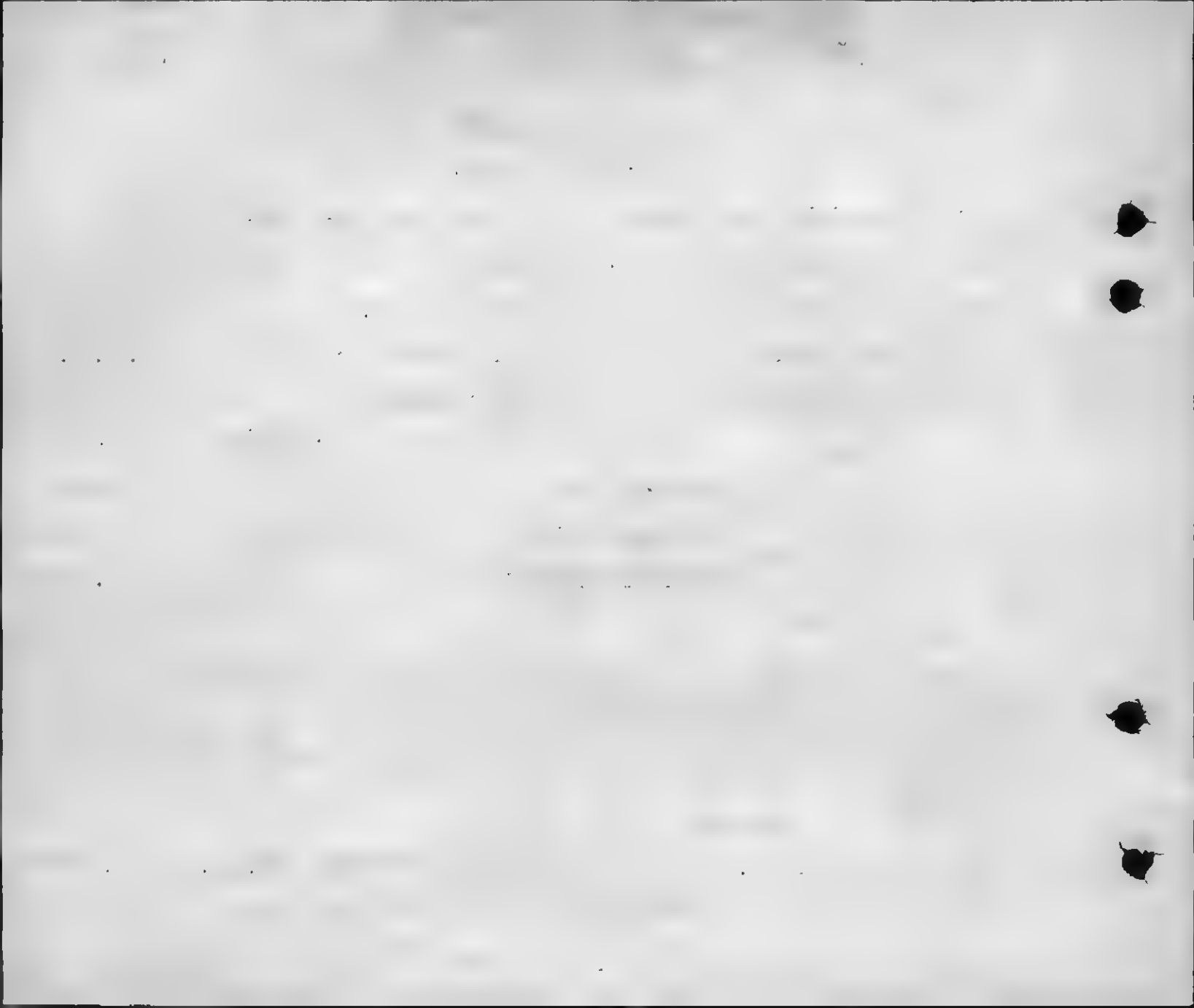
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08852

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 79 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2917 West North Avenue													
3. NAME OF DECEASED (Type or print) STANLEY G. HENRY		4. DATE OF DEATH Month August Day 28 Year 1961													
5. SEX Male		6. COLOR OR RACE Negro													
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 16, 1927													
9. AGE (In years last birthday) 34 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	10. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland									
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.													
13. FATHER'S NAME Stanley Henry		14. MOTHER'S MAIDEN NAME Virginia Harris													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 220-14-9247													
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <table border="1"> <tr> <td>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</td> <td>ENCEPHALOMALACIA</td> </tr> <tr> <td>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</td> <td>CIRRHOSIS OF LIVER</td> </tr> <tr> <td></td> <td>PANCREATIC LITHIASIS</td> </tr> </table>		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ENCEPHALOMALACIA	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	CIRRHOSIS OF LIVER		PANCREATIC LITHIASIS						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ENCEPHALOMALACIA														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	CIRRHOSIS OF LIVER														
	PANCREATIC LITHIASIS														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA - TERMINAL		19. INTERVAL BETWEEN ONSET AND DEATH 15 YEARS SEV. YEARS													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <table border="1"> <tr> <td>20c. TIME OF INJURY</td> <td>Month, Day, Year</td> <td>20d. INJURY OCCURRED</td> <td>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</td> </tr> <tr> <td>Hour a.m.</td> <td></td> <td>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></td> <td></td> </tr> <tr> <td>p.m.</td> <td>19</td> <td></td> <td></td> </tr> </table>		20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	Hour a.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		p.m.	19		
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												
Hour a.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
p.m.	19														
21. I certify that Dr. (this hospital) attended the deceased from June 10, 1961 , to August 28, 1961 , that Dr. (we) last saw the deceased alive on August 28, 1961 , and that death occurred at p.m. from the causes and on the date stated above. <table border="1"> <tr> <td>22a. SIGNATURE</td> <td>22b. DATE</td> </tr> <tr> <td><i>Sebastian Russo</i></td> <td>8/29/61</td> </tr> </table>		22a. SIGNATURE	22b. DATE	<i>Sebastian Russo</i>	8/29/61	22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.									
22a. SIGNATURE	22b. DATE														
<i>Sebastian Russo</i>	8/29/61														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-1-61													
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore 28, Maryland													
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR SEP 1 '61													
25b. REGISTRAR'S SIGNATURE <i>Charles E. Hanna</i>		25c. REGISTRAR'S SIGNATURE													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician, but this certificate has been signed by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

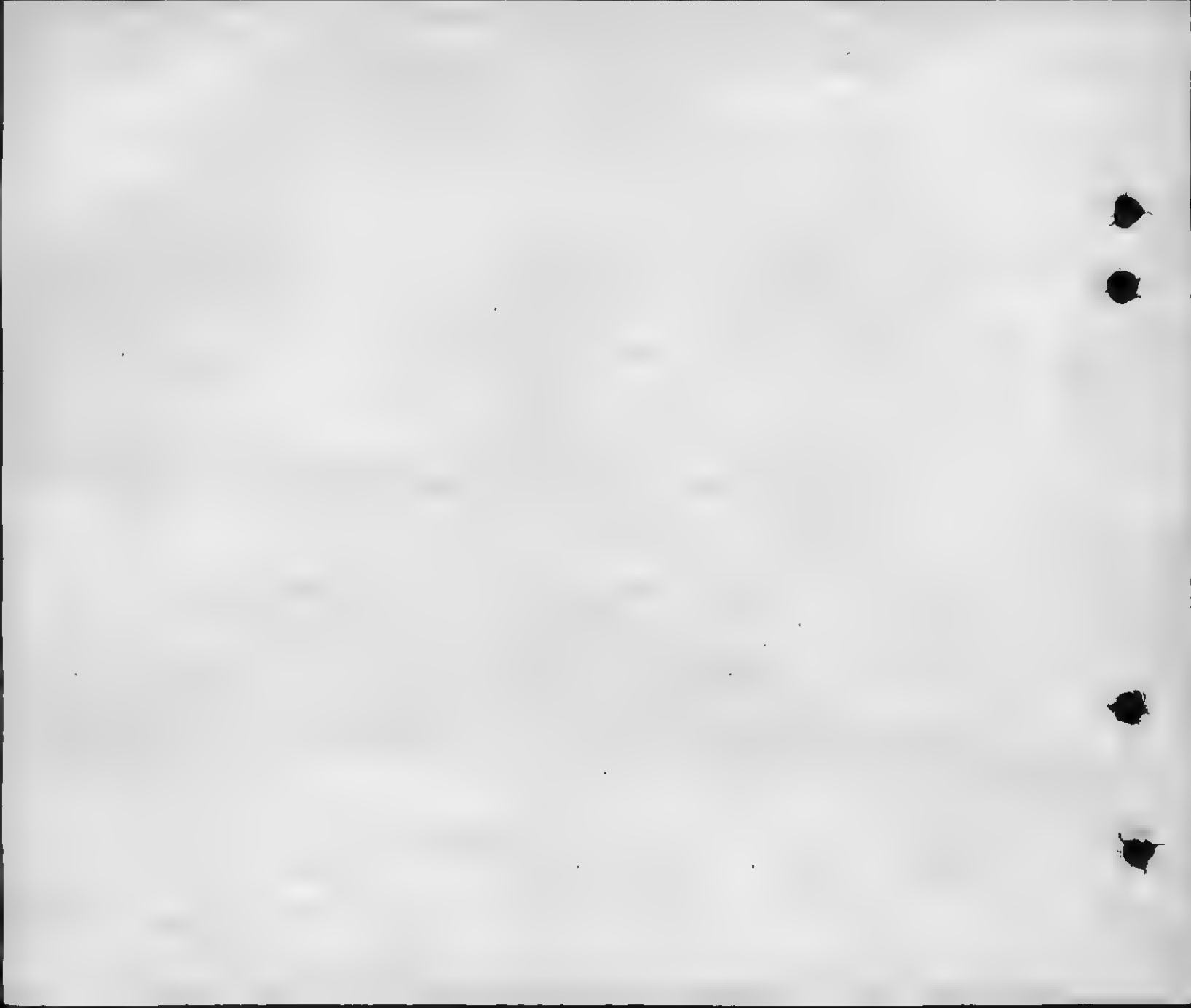
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 1 may be retained for your files. Page 2 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08853											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN 1b 6 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
3. NAME OF (Type or print) Henry Frederick Herrmann						d. STREET ADDRESS 13 Oakley Village					
5. SEX male						6. COLOR OR RACE white					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH Feb. 5, 1889					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman						10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.					
11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME unknown						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16. SOCIAL SECURITY NO. 1917-19					
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pulmonary infarction and thrombosis											
DU TO (b) Arteriosclerotic cardiovascular disease											
DU TO (c) Generalized arteriosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Bumper frac.; rt. leg from auto accident 7-20-61 -closed reduct. & cast at Fort Howard Hosp. - subsequent gangrene of the right leg											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18.) Pt. struck by automobile on 7-20-61 sustaining bumper frac. right leg											
20c. TIME OF INJURY Month, Day, Year 7-20 19 61											
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street											
20e. (City or town) Baltimore, Maryland (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) 1010 Lerdan											
DATE SIGNED 8-3-61											
ACTUAL SIGNATURE Geo. M. Kieffer											
EXAMINER'S NAME (Type) George M. Kieffer, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 8-7-61											
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL BALTIMORE											
22d. LOCATION (City, town, or country) (State) Md.											
23. FUNERAL DIRECTOR Geo. T. Schwab ADDRESS 2101 Lerdan Ave.											
24a. REC'D BY REGISTRAR AUG 4 '61 DATE											
24b. REGISTRAR'S SIGNATURE Wm. S. Hume											

M



Item 2 Film G294 - 9/5/61 - in

Arthur S. Kraus

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08855

1. NAME OF DECEASED
(Type or Print)

8862

MRS. ANNA M. HORN

2. DATE OF DEATH

AUGUST 3, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MERCY VILLA

BELLONA AVE

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS

(If rural, give location)

1006 E. 20TH. STREET

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

ABOUT 76

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10. A USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired)

HOUSEWIFE

10a. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

MICHAEL GAENG

14. MOTHER'S MAIDEN NAME

GERTRUDE C. SCHILLING

15. Was Deceased Ever in U S. Armed Forces?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. MAY A OREM 116 W. UNIVERSITY

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying e.g.
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) Arterio sclerotic cardio-
vascular disease

(B) _____
DUE TO

(C) _____
DUE TO

INTERVAL BETWEEN
ONSET AND DEATH Pky.
10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?
YES ☐ NO ☒

22. I certify that (I) (the hospital) attended the deceased from December 10, 1955 to August 3, 1961, that (I) (we) last saw the deceased alive on July 29, 1961, and that in (my) (our) opinion death occurred at 6:25 A.M. from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐ M.D.

Eleven East Chase Street

8-4-61

24a. BURIAL, CREMATION,
REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

(City, town, or county)

(State)

BURIAL

8/5/61

HOLY REDEEMER

BALTIMORE, MARYLAND

25a. DATE REC'D BY HEALTH DEPT.

25b. NAME OF REGISTRAR

25c. FUNERAL DIRECTOR

ADDRESS

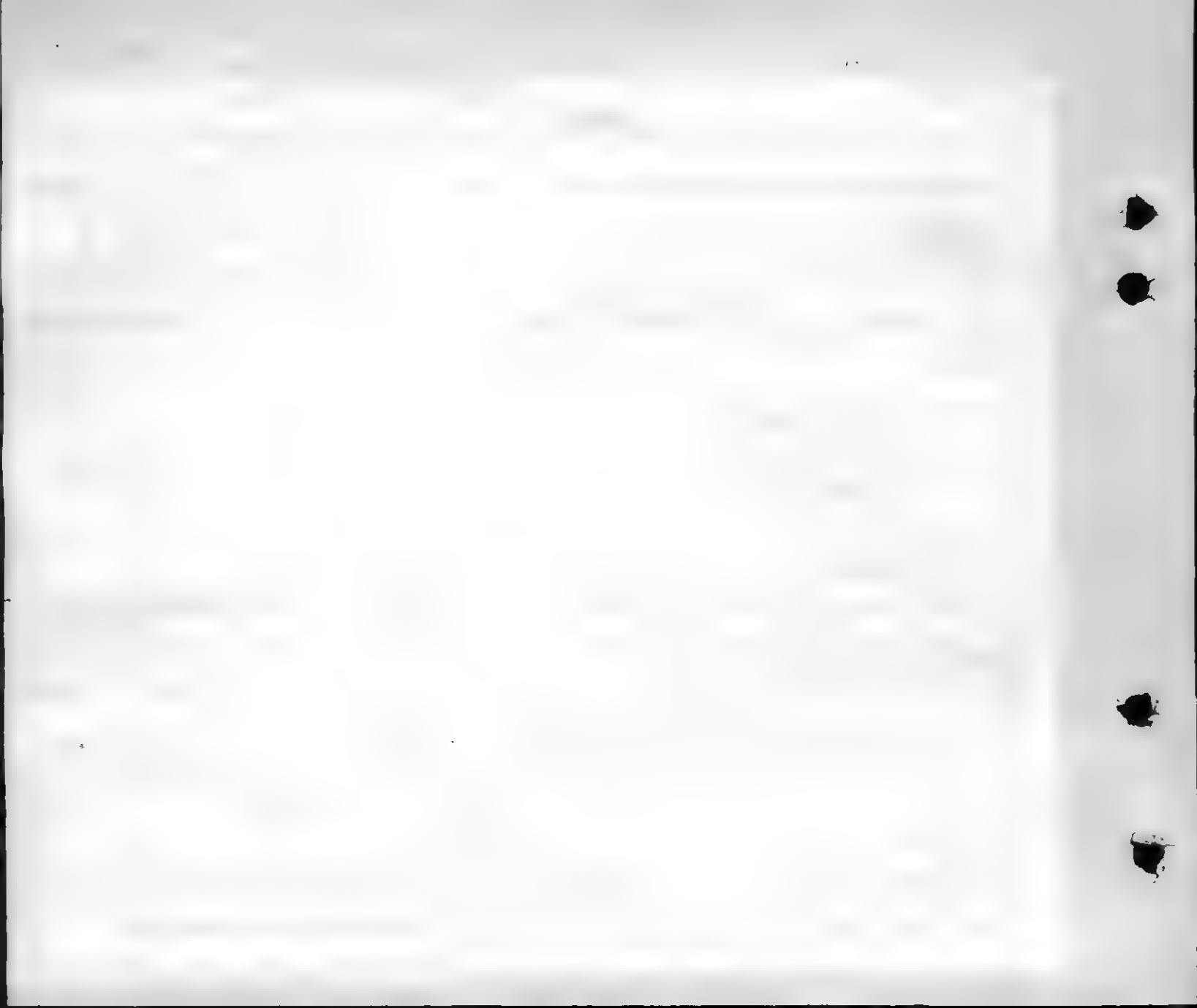
AUG 9 '61

Wm. S. Kneass

H.W. MEARS & SON 805 N. CALVERT ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the funeral director. For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

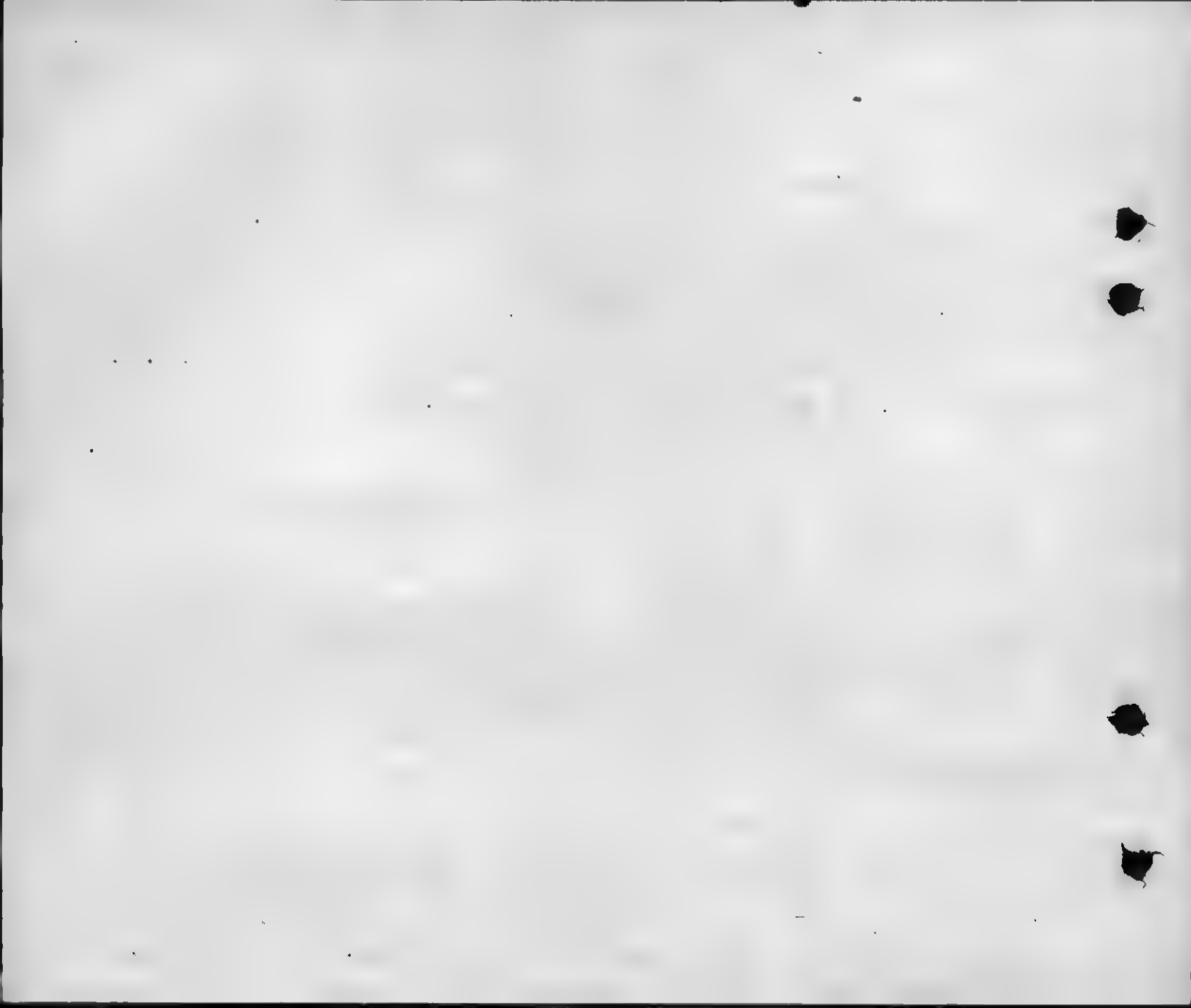
8863

08856

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Contonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3001 4</u> d. STREET ADDRESS <u>1553 Winston Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First Middle Last		4. DATE OF DEATH <u>August 21 1961</u> Month Day Year		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>7</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>79</u>
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 11, 1881</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE <u>U. S. A.</u> County & State, or foreign country		
13. FATHER'S NAME <u>Bernard J. Hubbell</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary C. Thomason</u> 17. INFORMANT <u>Miss Catherine Hubbell-1553 Winston Ave.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 17, 1961</u> to <u>AUGUST 21, 1961</u> that (I) (we) last saw the deceased alive on <u>AUGUST 19, 1961</u> and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>Herbert L. Blumentfeld</u> 22c. PHYSICIAN'S NAME (Type) <u>HERBERT L. BLUMENTFELD</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2104 Gwynn Oak Av., BALTO. 7, MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons</u>		25a. REC'D BY REGISTRAR <u>Balto. 17, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

MEDICAL CERTIFICATION

TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the health certificate be executed within 24 hours after death. On 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8864

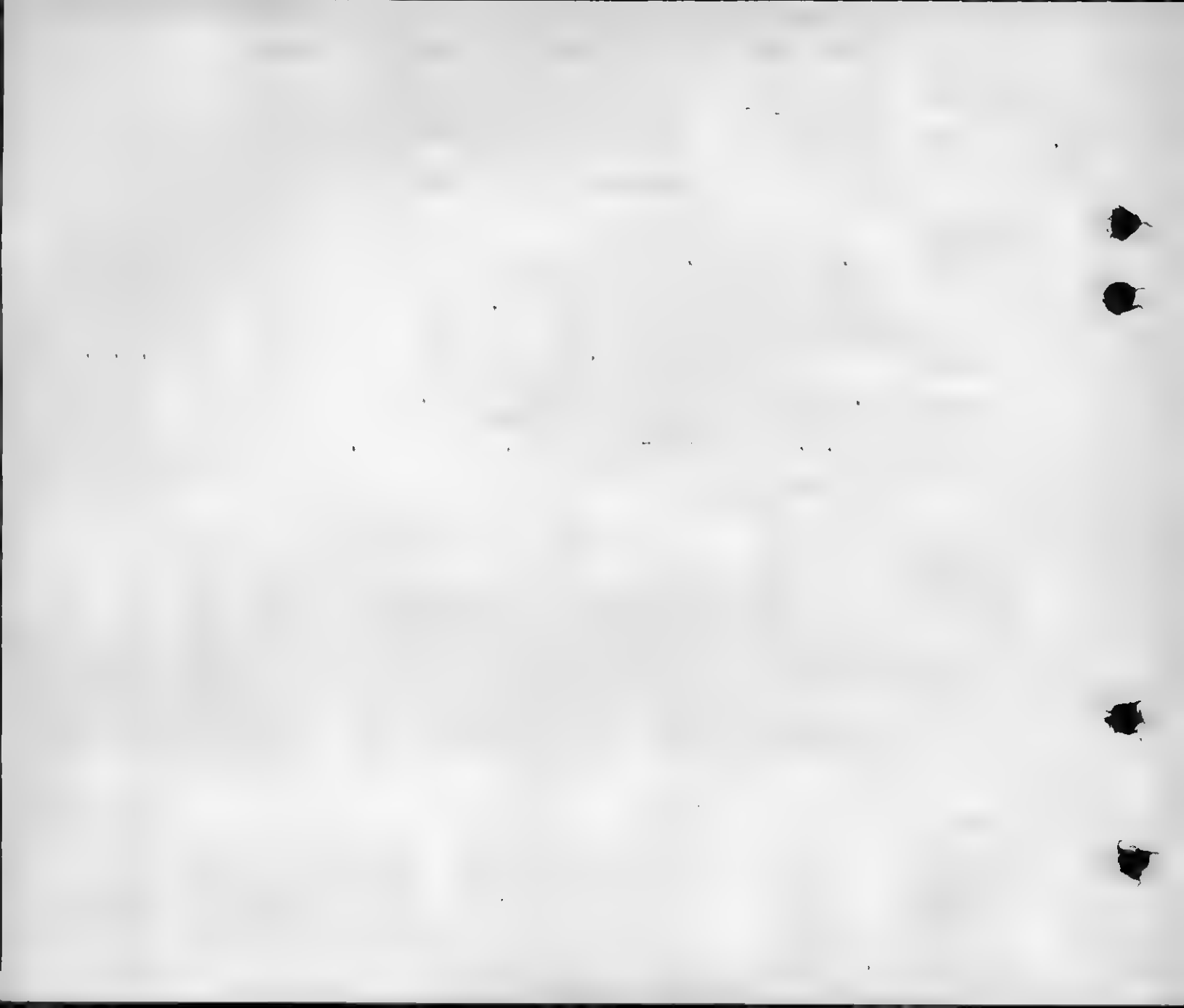
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08857

1. PLACE OF DEATH a. COUNTY <u>Catonville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Catonville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6002 Moorehead Road</u>		d. STREET ADDRESS <u>6002 Moorehead Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Louis S. Humphreys</u>		4. DATE OF DEATH Month <u>18</u> Year <u>1961</u> <u>August 27</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1927</u>
9. AGE (in years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward J. Humphreys</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Schlag</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>274-24-5009</u>	
17. INFORMANT <u>Mrs. Darlene C. Humphreys</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO <u>hanging himself from rafters</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>suicide in cellar</u> DUE TO <u>suicide</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bal to</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>hanging himself by cloth line from rafters in cellar</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Aug 28 9 51</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Catonville</u> (County) <u>Bald</u> (State) <u>Cal</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>GEO S. H. KUEFFER</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO S. H. KUEFFER, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>AUG 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>O. H. S. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please enter "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for you. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician, complete and fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118858

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY (in days) **12 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **538 W. Hoffman Street -1**
d. STREET ADDRESS **Baltimore**

3. NAME OF DECEASED (Type or print)
ANDREW JACKSON
First Middle Last

4. DATE OF DEATH **August 5, 1961**
Month Day Year

5. SEX **Male**
6. COLOR OR RACE **Negro**
7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **November 9, 1894**
WIDOWED ☐ DIVORCED ☐ 9. AGE (in years last birthday) **66** yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Gardner**
10b. KIND OF BUSINESS OR INDUSTRY **Private Families**
11. BIRTHPLACE (City & State, or foreign country) **Talbot County, Maryland**
12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13. FATHER'S NAME **William Jackson**
14. MOTHER'S MAIDEN NAME **unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes WW-1**
16. SOCIAL SECURITY NO **214-22-8230**
17. INFORMANT **Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. -FORT HOWARD DIVISION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **PULMONARY EMBOLUS**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **CARCINOMA OF COLON, POST OPERATIVE**
DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

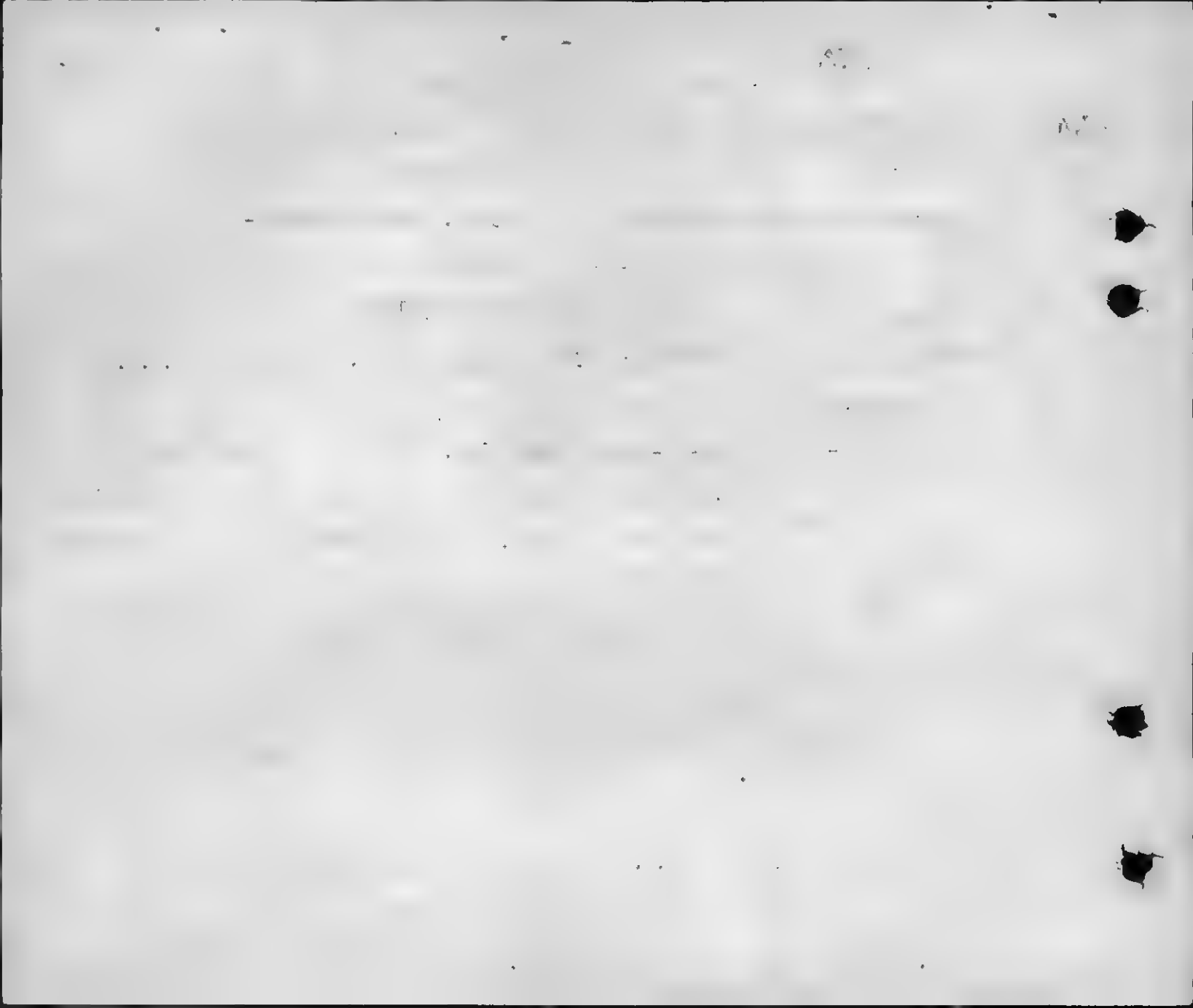
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

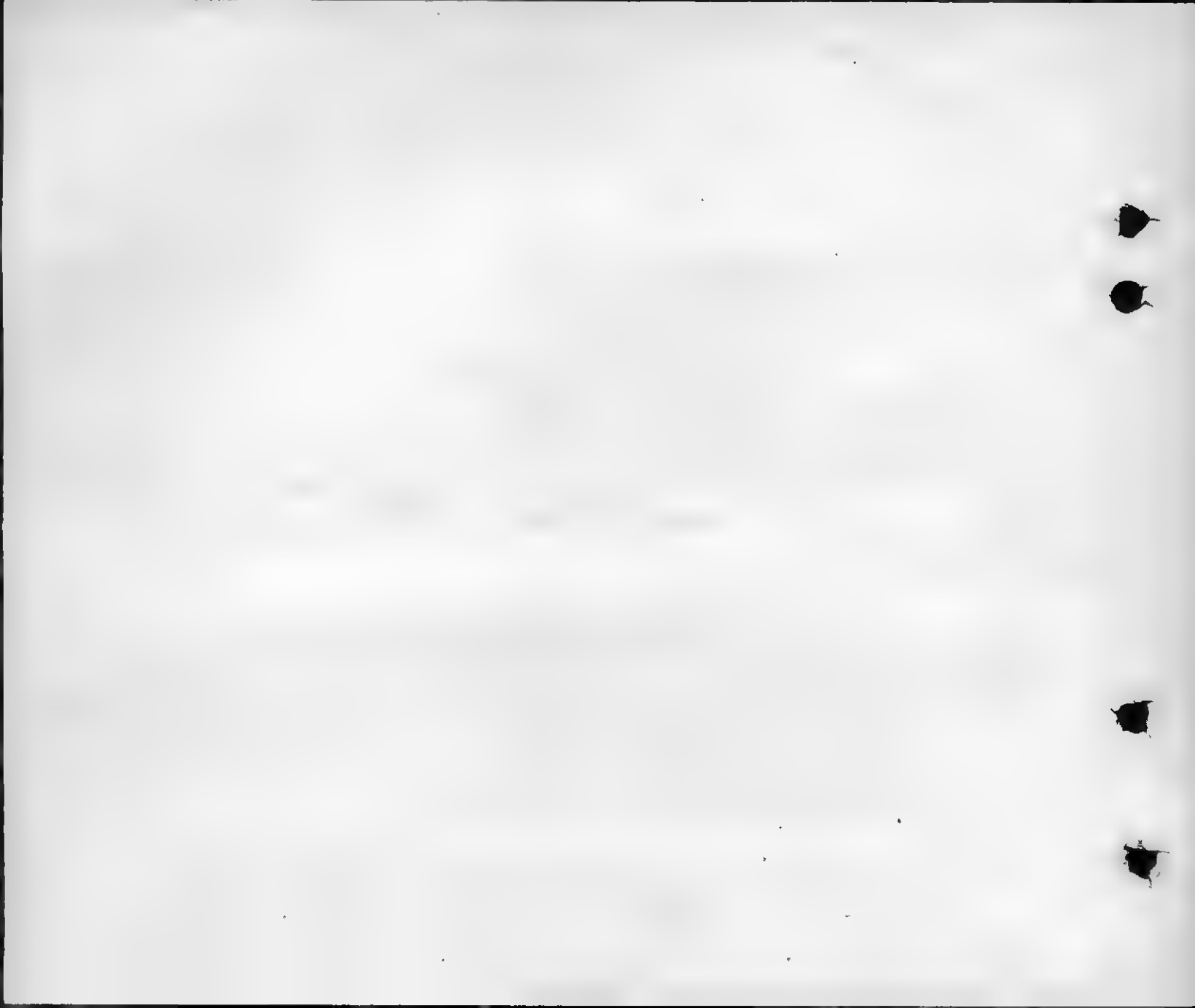
21. I certify that ☒ (this hospital) attended the deceased from **July 24, 1961** to **August 5, 1961**, that ☒ (we) last saw the deceased alive on **Aug. 5, 1961**, and that death occurred at **10:37** M., from the causes and on the date stated above.

22a. SIGNATURE **Ernest O. Brown, M.D.**
22b. DATE SIGNED **8/6/61**
22c. PHYSICIAN'S NAME (Type) **ERNEST O. BROWN, M.D.**
22d. ADDRESS **VAH Fort Howard, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
23b. DATE THEREOF **8-8-61**
23c. NAME OF CEMETERY OR CREMATORY **Baltimore National Cemetery**
23d. LOCATION (City, town or county) (Site e) **Baltimore Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Elroy O. Wilson**
25a. REC'D BY REGISTRAR **Aug 17 '61**
25b. REGISTRAR'S SIGNATURE **Ernest O. Brown**





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08861

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 1/2 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last Keene, Sr.		4. DATE OF DEATH Month August Day 4 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1866
9. AGE (In years lost birth day) 94 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Thomas Henry Keene		14. MOTHER'S MARDEN NAME Eliza Emory Travers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT LECOMPTRE FUNERAL SERVICE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMACIATION			
1. 1.3 DUE TO METASTATIC CARCINOMA RIGHT SUBMANDIBULAR NODE (PRIMARY SITE RT. ALA NASI)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIO SCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG. 1 19 61 , to AUG. 4 19 61 , that (I) (we) last saw the deceased alive on AUG. 1 19 61 , and that death occurred at 623 M, from the causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		22b. ADDRESS 206 W. Pennsylvania Avenue, Towson, Md.	
22c. PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D.		22d. ADDRESS 206 W. Pennsylvania Avenue, Towson, Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	8/7/61	Old Trinity Cemetery	Church Creek, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home, Cambridge, Maryland		25a. REC'D BY REGISTRAR AUG 9 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur J. Kinn	

22b. DATE SIGNED
8/4/61

22c. PHYSICIAN'S NAME (Type)
Thaddeus C. Siwinski, M.D.

22d. ADDRESS
206 W. Pennsylvania Avenue, Towson, Md.

22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

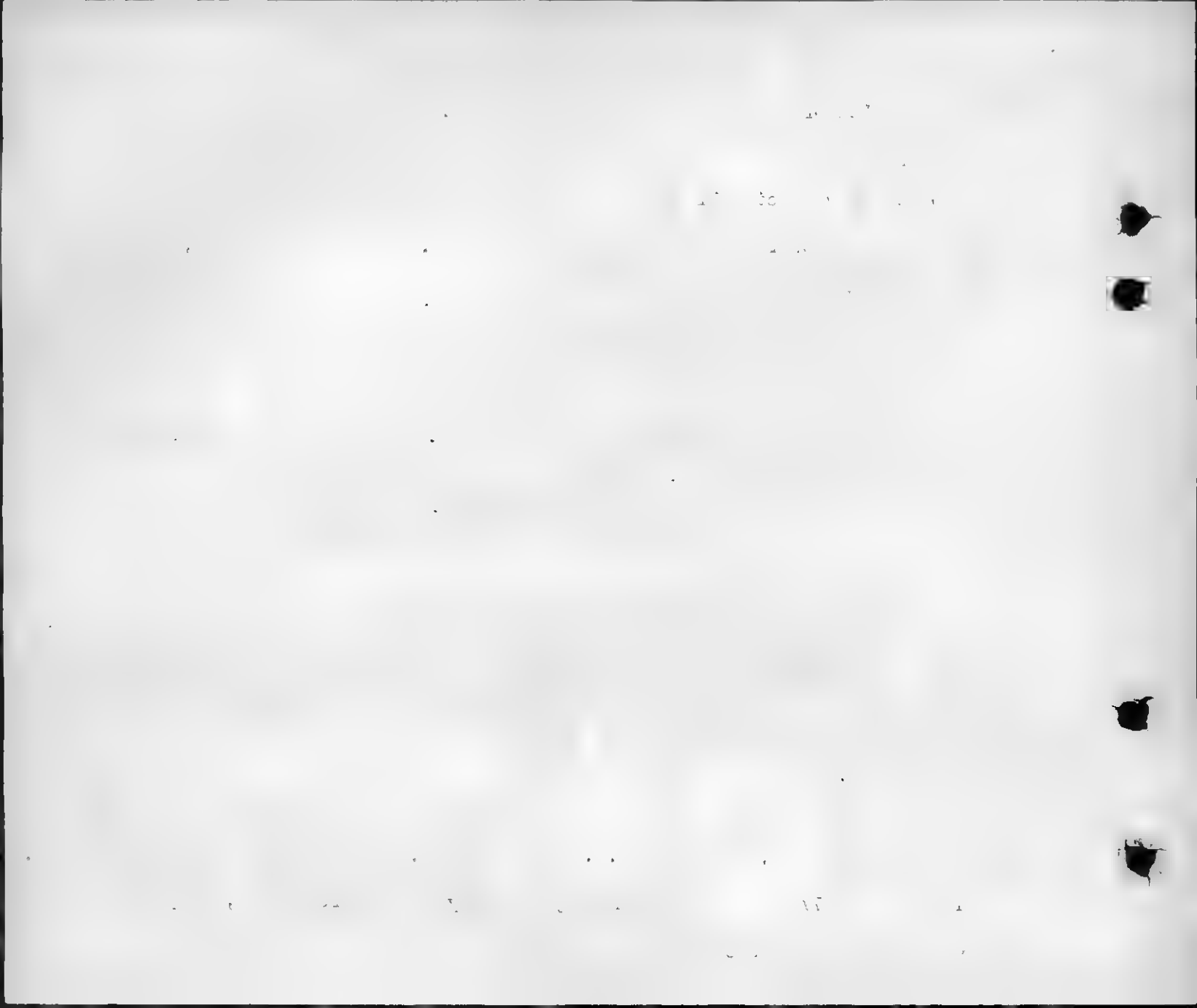
22f. (City or town) (County) (State)

22g. SIGNATURE
Arthur J. Kinn

22h. ADDRESS
206 W. Pennsylvania Avenue, Towson, Md.

22i. DATE SIGNED
8/4/61

22j. SIGNATURE
Arthur J. Kinn



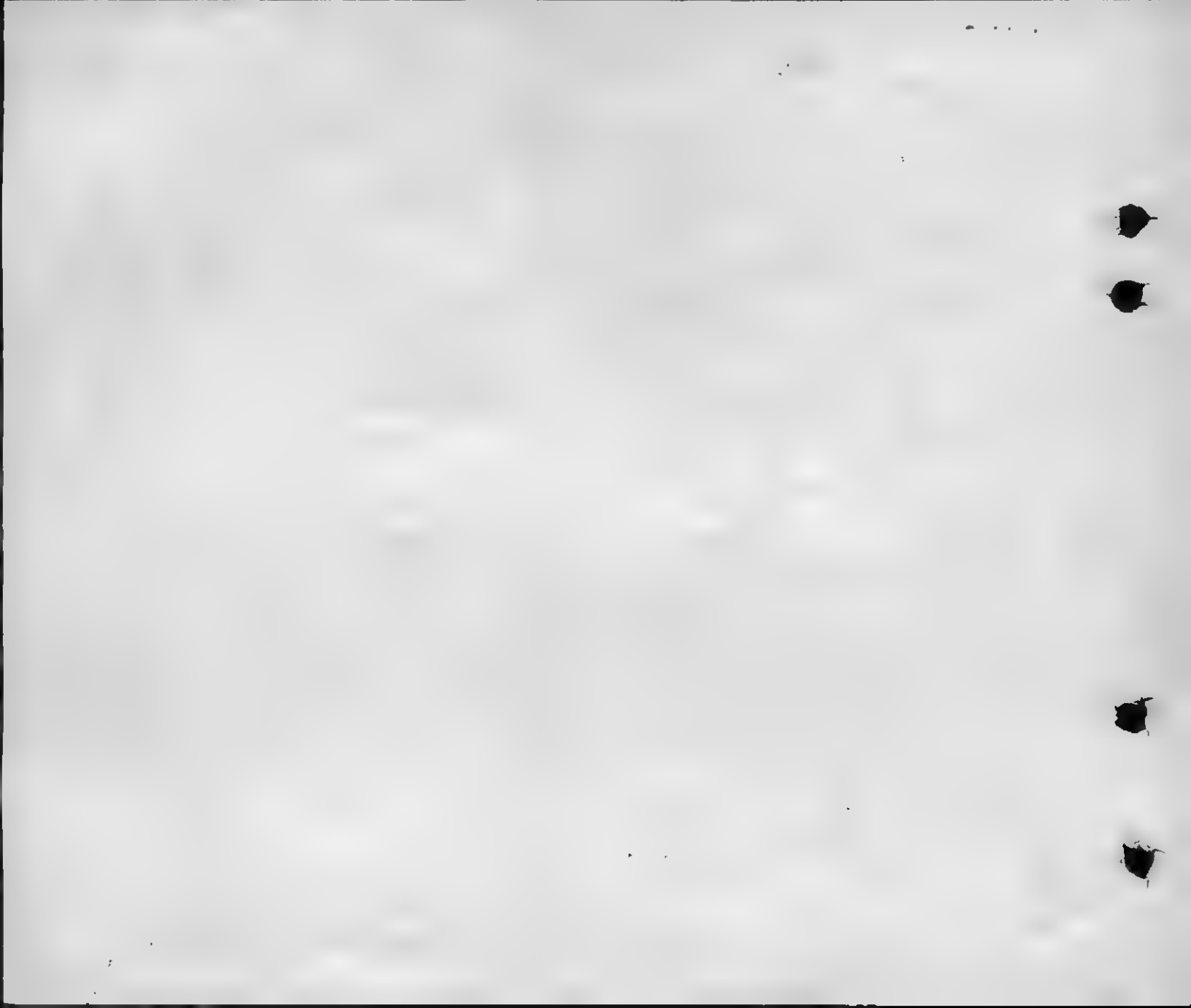
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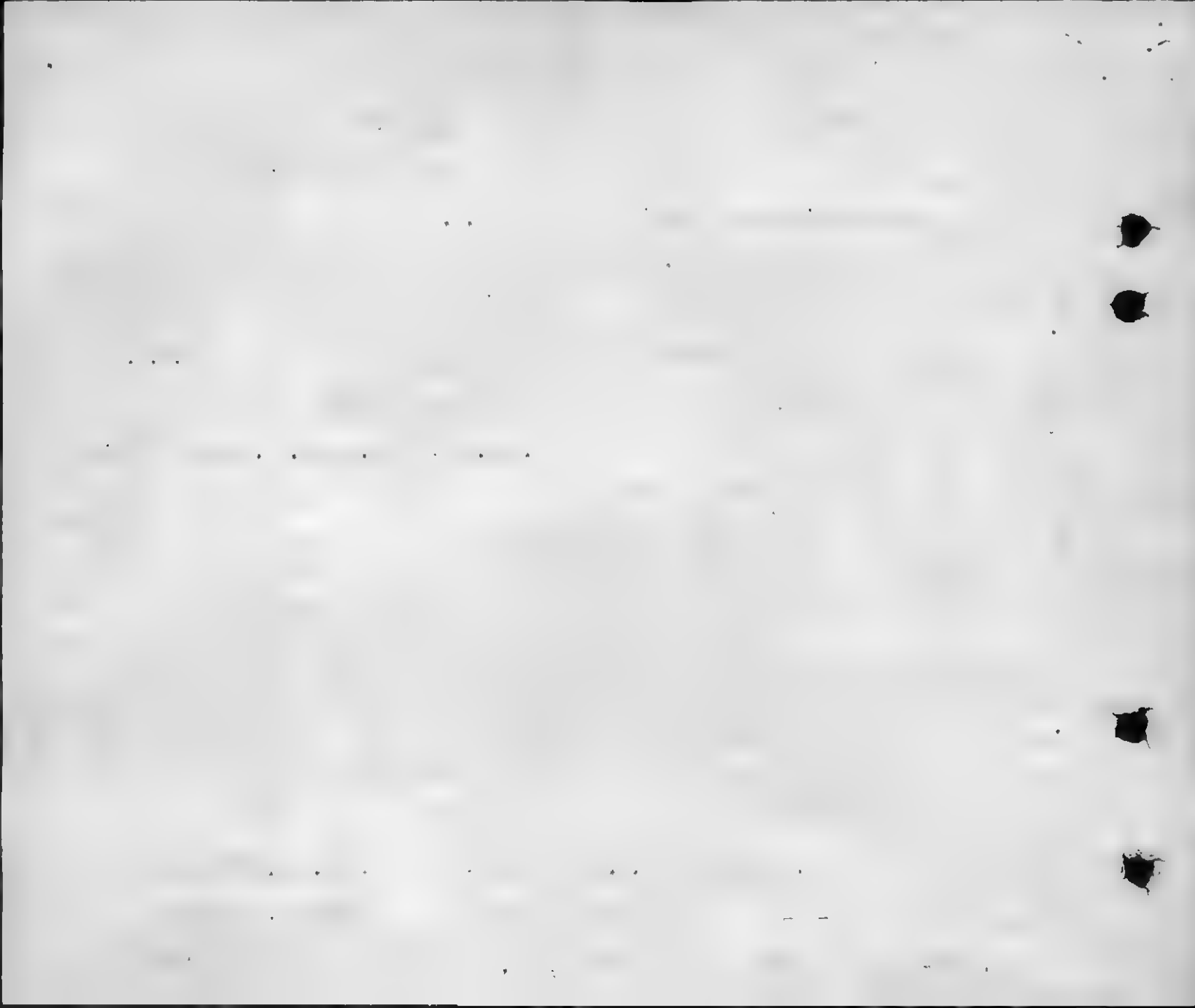
CERTIFICATE OF DEATH

8869

418269

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 2017 Hammonds Ferry Road	
3. NAME OF DECEASED (Type or print) Matabel Kelly		4. DATE OF DEATH Month August Day 18 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 18 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Cooper		14. MOTHER'S MAIDEN NAME Ida Mandy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 214-20-9945	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 430.0 DUE TO (b) Sub-acute bacterial endocarditis 100.0 with Lung, pancreas, spleen abscesses (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (If (this hospital) attended the deceased from March 12, 1959 to Aug. 18, 1961 , that (I) (we) last saw the deceased alive on Aug. 18, 1961 , and that death occurred at 8:05 A.M. from the causes and on the date stated above			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 8-18-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/21/61	23c. NAME OF CEMETERY OR CREMATORY London Park Cem	23d. LOCATION (City, town or county) (State) Beckto Md
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny		25a. REC'D BY REGISTRAR AUG 22 1961	
ADDRESS 11000 Hollins Ave		25b. REGISTRAR'S SIGNATURE J. H. H. H.	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

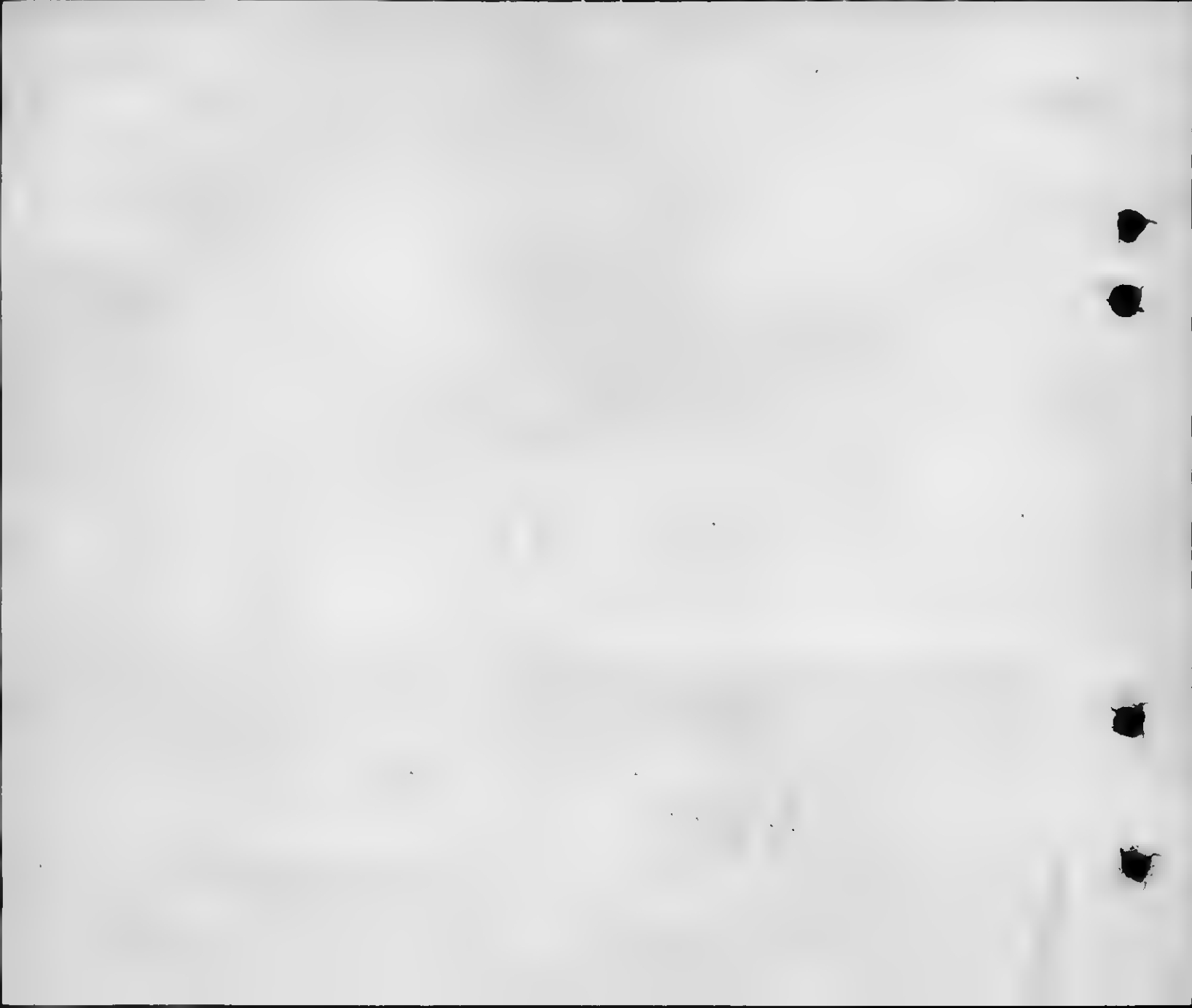
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8871

118864

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOUSE IN PINES</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>123 OVERBROOK RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DRUCILLIA A. KERSHAW</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 10, 1900</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13. FATHER'S NAME <u>CARVIL S. MASON</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL ROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>14-08-10-1000</u>	
17. INFORMANT <u>Mr. Charles R. Kershaw, 23 Overbrook Dr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO <u>Autostatic Ca of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Carcinoma of Ad. Ovary</u> DUE TO <u>Carcinoma of Ad. Ovary</u>	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		20. INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>1 yr.</u> <u>2 1/2 yrs.</u>	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from <u>1-15</u>, 19<u>57</u>, to <u>8-1</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>8-1</u>, 19<u>61</u>, and that death occurred at <u>6 P.M.</u>, from the causes and on the date stated above.			
28. SIGNATURE <u>Wilmer K. Gallagher</u>		29. DATE SIGNED <u>8-3-61</u>	
30. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>		31. ADDRESS <u>6207 Frederick Ave, Baltimore 28, Md.</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>8-4-61</u>	
34. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		35. LOCATION (City, town or county) <u>Balto.</u>	
36. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Carrington</u>		37. ADDRESS <u>B.F.H. Catonsville, Md.</u>	
38. REC'D BY REGISTRAR <u>DATE AUG 7 '61</u>		39. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2873

CERTIFICATE OF DEATH

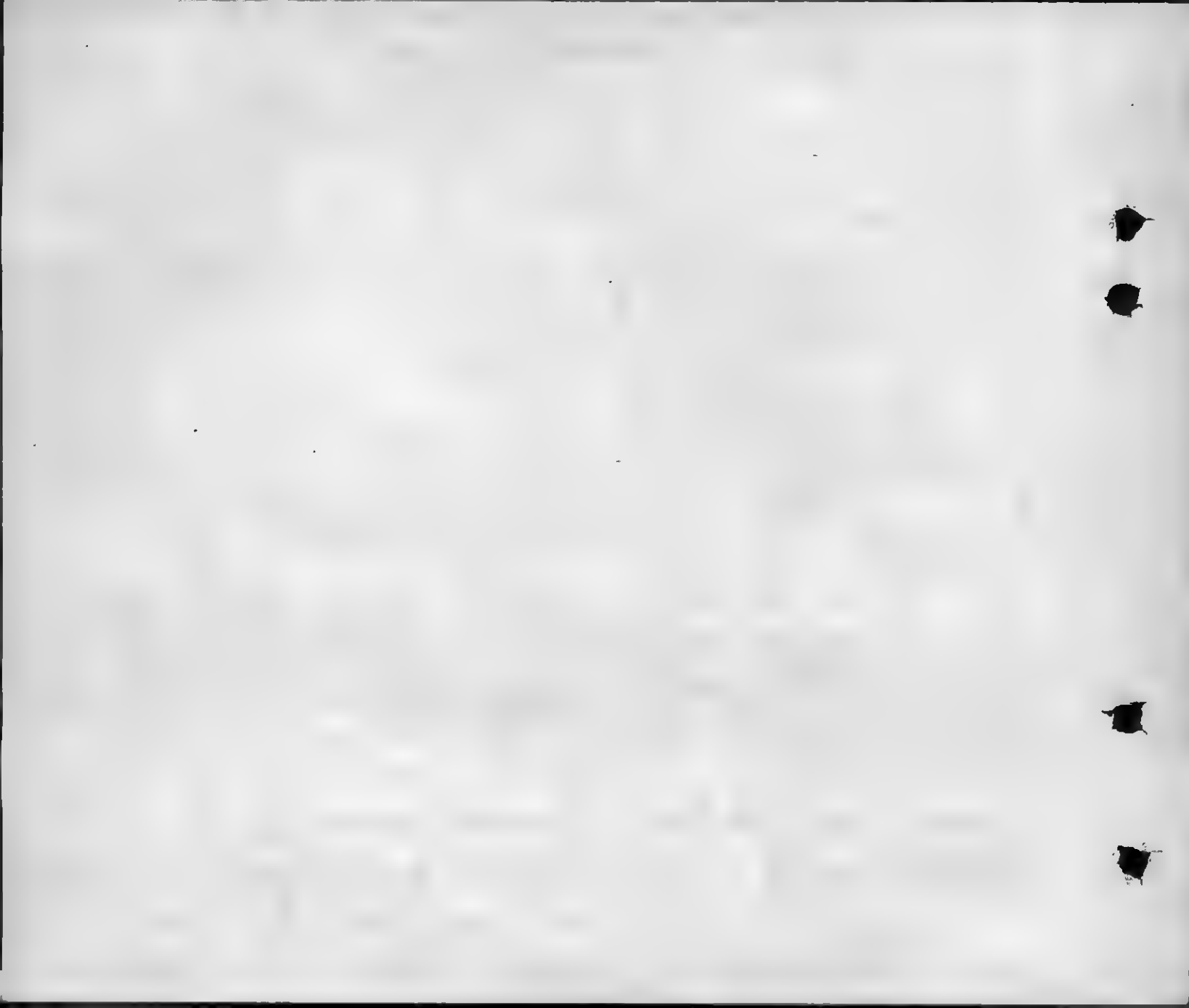
Reg. Dist. No.

112866

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES (TINGER)		e. STREET ADDRESS 604 S. ELLWOOD AVE	
3. NAME OF DECEASED (Type or print) First CARRIE Middle KOEHLER Last KOEHLER		4. DATE OF DEATH Month AUG. Day 3 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY MD.	11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. D. RUTKOWSKI		Address 743 S. CONKLING ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Branch-pneumonia. DUE TO (b) Chronic Hypertensive Cardio-Vascular Renal Disease DUE TO (c) 1037 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-30-1961 to 8-3-1961 , that I last saw the deceased alive on 8-3-1961 , and that death occurred AT 1:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William K. Gallagher		ADDRESS (Street, city or town, state) 6209 Frederick Road	
PHYSICIAN'S NAME (Type) William K. Gallagher, M.D.		DATE SIGNED 8-3-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 7, 61	
22c. NAME OF CEMETERY OR CREMATORY DAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G.W. Hoffmann		ADDRESS 3218 HUDSON ST.	
24a. REC'D BY REGISTRAR AUG 4 '61		24b. REGISTRAR'S SIGNATURE William S. Kenna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 18867

8874

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTC.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN TB d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8219 BELAIR RD</u>				d. STREET ADDRESS <u>18219 BELAIR RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Krank</u> Middle <u>J</u> Last <u>Kurek</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 4 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS KUREK</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR STUPZINSKI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY KUREK 8219 BELAIR RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Failure</u> DUE TO (c) <u>Coronary Insufficiency</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right hemiplegia secondary to old Cerebral Thrombosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 21</u> , 1959, to <u>Aug. 16</u> , 1961, that I last saw the deceased alive on <u>Aug. 3</u> , 1961, and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9660 Belair Rd., Balto. 6, Md.</u> DATE SIGNED <u>August 17 '61</u>							
ACTUAL SIGNATURE <u>Theodore E. Evans, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M.D. 9660 Belair Rd., Balto. 6, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-19-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>PUNDALK AVE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M WEBER & SONS INC. 4015 CHESTER ST</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08868

1. NAME OF DECEASED
(Type or Print)

2875

ERNEST C. LAMBERT

2. DATE OF DEATH

AUG 7, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

1213 FAIRFIELD AVE

4. USUAL RESIDENCE (Where deceased lived If institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE CO

D. STREET ADDRESS

(If rural, give location)

1213 FAIRFIELD AVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9-7-08

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

9

10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired)

WELDER

10. B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JOSEPH LAM

14. MOTHER'S MAIDEN NAME

MARY HOLLAR

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

NO

(If yes, give war or dates of service)

NONE

16. SOCIAL
SECURITY NO.

216-07-4585

17. INFORMANT

CHARLES C. BRADFORD

ADDRESS

1213 FAIRFIELD AVE

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Carcinomatous

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

malignant lymphoma

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19. OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐

NO ☐

22. I certify that (I) (this hospital) attended the deceased from

Aug 7

19 61

that (I) (we) last saw the deceased alive on

April

Aug 2

19 61

and that in (my) (our) opinion death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

Edward H. Hossman

23B. ADDRESS

4037 Falls Rd.

23C. DATE SIGNED

8/7/61

24A. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8-9-61

24C. NAME OF CEMETERY OR CREMATORY

JESSOPS CEMETERY

24D. LOCATION

(City, town, or county)

BALTIMORE CO, MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

259 90P

11/2/61

August E. Donovan

3818 Roland Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician and may be filed by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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M

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
8876 CERTIFICATE OF DEATH 08869											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON c. LENGTH OF STAY IN 1b LIFE				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON d. STREET ADDRESS 14201 FULLERTON AVE.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4201 FULLERTON AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WALTER Middle IE Last LESSAHN				4. DATE OF DEATH Month 8 Day 25 Year 1961							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/1894		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MECHANIC.				10b. KIND OF BUSINESS OR INDUSTRY OWN.		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FREDERICK LESSAHN				14. MOTHER'S MAIDEN NAME ELIZABETH DOMER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 215-32-8087		17. INFORMANT MARTHA LESSAHN 4201 FULLERTON AVE Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of aorta DUE TO (b) Bronchogenic Carcinoma Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Obstruction; Myocardial Degenerative Disease.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1961 to Aug 25, 1961 . That (I) (we) last saw the deceased alive on Aug 15, 1961 and that death occurred at 1 p.m. from the causes and on the date stated above											
22a. SIGNATURE John C. Hyle				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8-28-61					
22c. PHYSICIAN'S NAME (Type) JOHN C. Hyle				22d. ADDRESS 7527 Belair Rd Balto 6							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/28/1961		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) BALTO CO MD			
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Road #4		25a. REC'D BY REGISTRAR AUG 30 '61		25b. REGISTRAR'S SIGNATURE William S. Kraus			



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8877

CERTIFICATE OF DEATH

08870

Item 2 Film G293 8/25/61 mh

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Md b. COUNTY Baltimore Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calonsville/ Solomons Island 04 X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forrest Haven Nursing Home		d. STREET ADDRESS /313 Ingleside Ave/ • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY E. LEATHERING First Middle Last		4. DATE OF DEATH Aug. 14, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1889 yrs. 71
9. AGE (In years lost birthday) 71		IF UNDER 1 YEAR Months 8 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? XXXXX U. S. A.	
13. FATHER'S NAME John H. O'Bery		14. MOTHER'S MAIDEN NAME Lulie Clocker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Nursing Home Records		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.P.V.D. E myocardial infarction 3 hours 7 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1958 to Aug. 12, 1961 that (I) (we) last saw the deceased alive on Aug. 1, 1961 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Shedue F. Paulson M.D.		22b. DATE SIGNED 8/15/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/61	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town, or county) (State) Calvert County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE A.A. Harkness & Son, Mutual, Calvert Co., Md.		25a. REC'D BY REGISTRAR DATE AUG 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, complete and fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 24, Film G-295 9/14/61 iwk

Item 23b, Film G-295 9/21/61 iwl

09941

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN lb

2 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

CHARLES

C. G.

LEONARD

5. SEX

Male

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

August 4, 1879

4. DATE OF DEATH

Month

Day

Year

August

24

19 61

9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

82 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Brick Mason- Retired

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (County & State, or foreign country)

Caroline Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles H. Leonard

14. MOTHER'S MAIDEN NAME

Elizabeth Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes

SAW

16. SOCIAL SECURITY NO.

214-07-7207

17. INFORMANT

Clinical Records, VAH, Baltimore 18, Maryland

FORT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

HEART FAILURE

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH UNKNOWN

UNKNOWN

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from August 22, 1961, to August 24, 1961, that (X) (we) last saw the deceased alive on August 24, 1961, and that death occurred at 11:35 P.M. from the causes and on the date stated above

22a. SIGNATURE

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED 8/25/61

22c. PHYSICIAN'S NAME (Type)

THOMAS F. CRAHAN, M.D.

VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

8/28/61

23c. NAME OF CEMETERY

Dorchester Memorial Park

23d. LOCATION (City, town or county)

Cambridge

(State)

Maryland

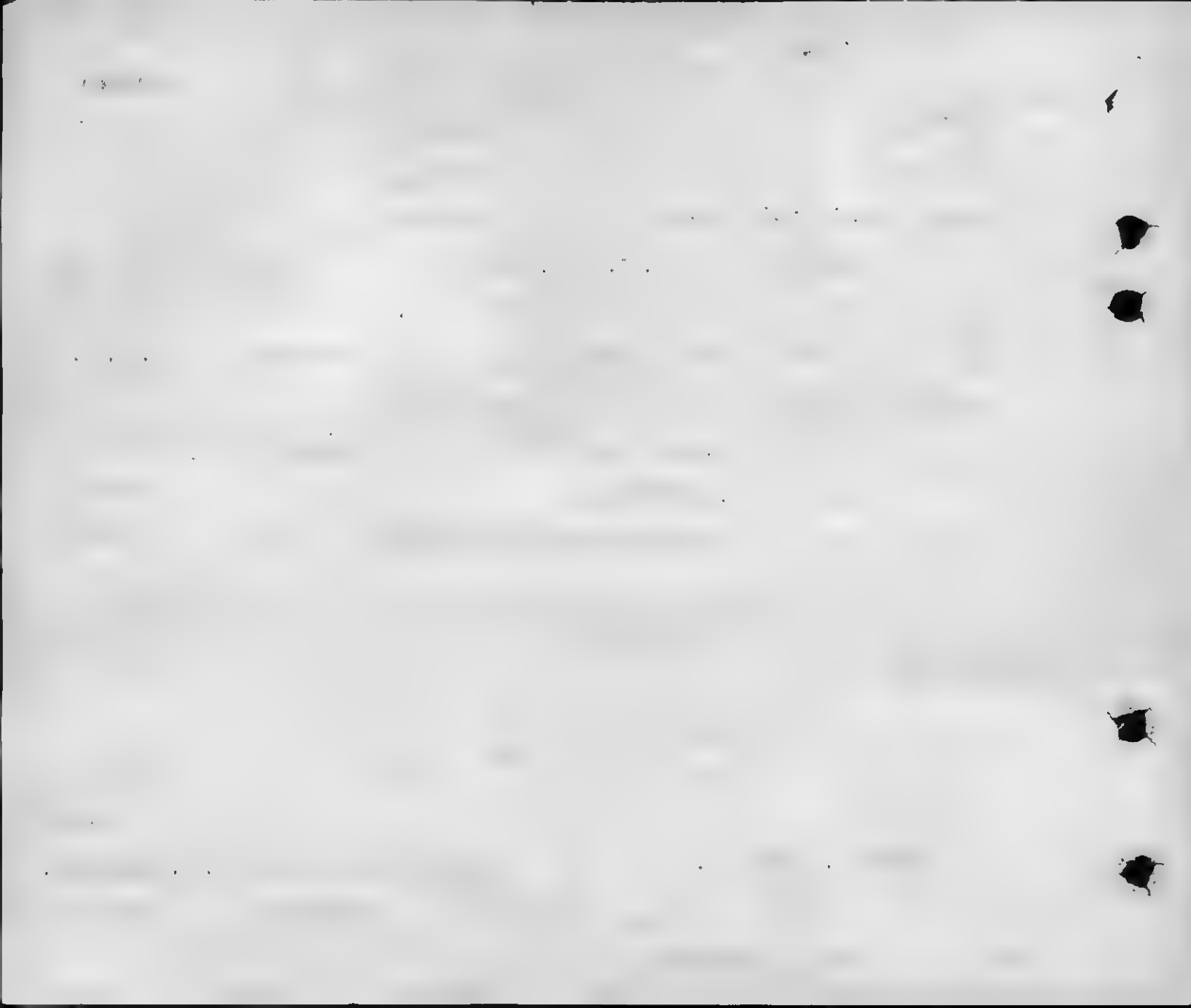
24. FUNERAL DIRECTOR'S SIGNATURE

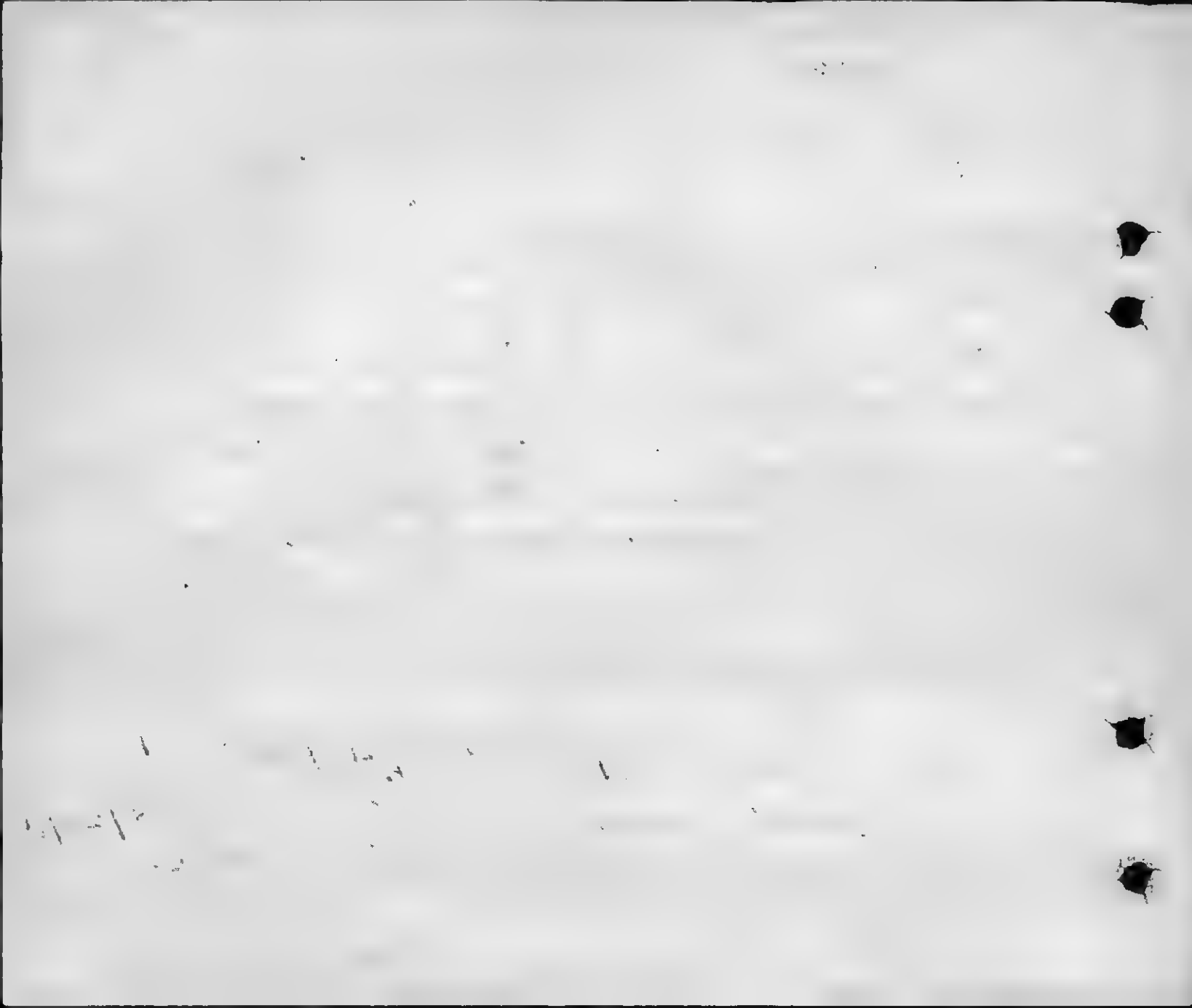
Le Compte Funeral Home, High Street, Cambridge, Md.

25a. REGISTERAR

25b. REGISTRAR'S SIGNATURE

Carlton S. Kraus





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8880

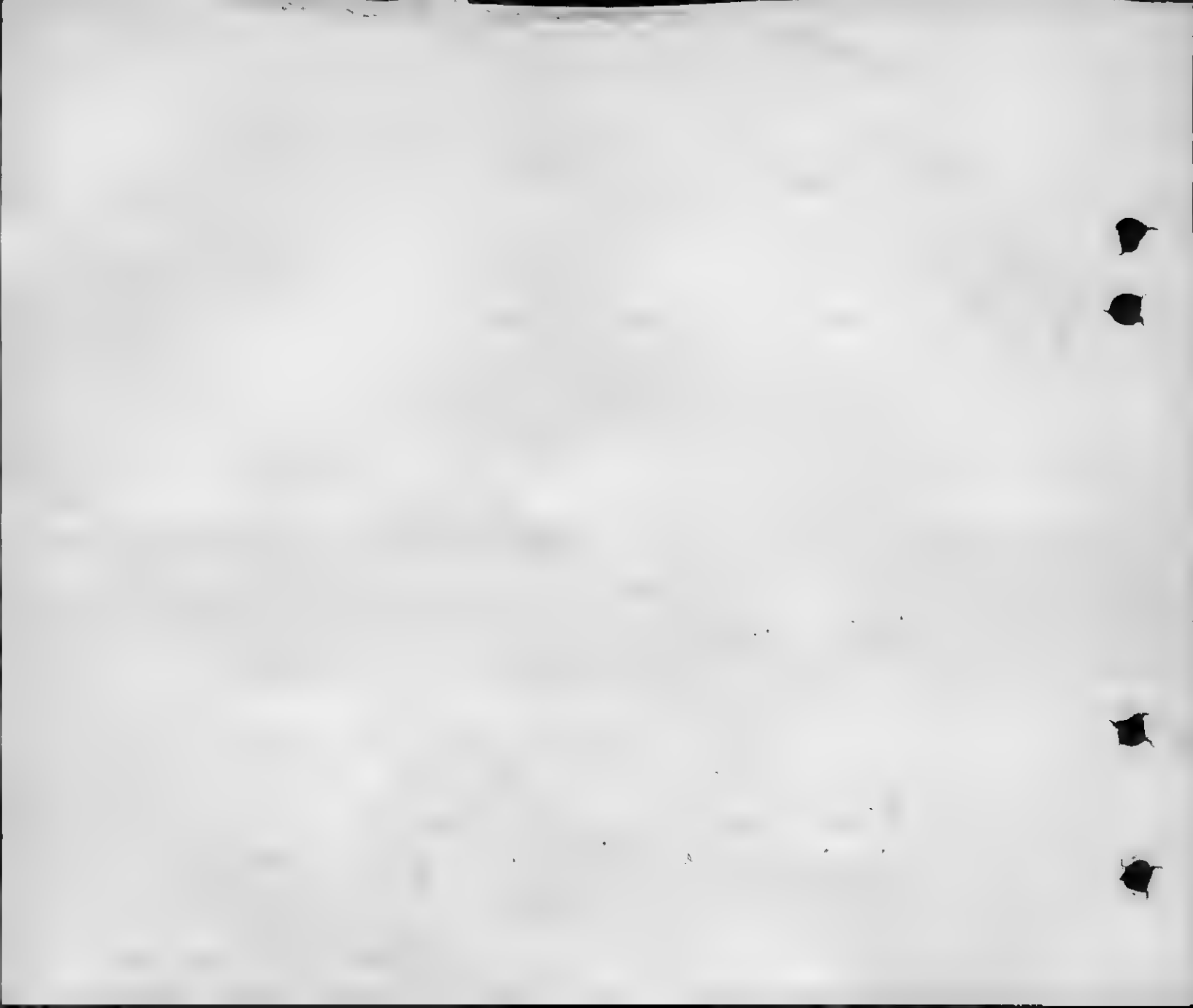
CERTIFICATE OF DEATH

08872

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>24 Locust St.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 Locust St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>24 Locust St.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY G. LOCHENAUER</u> First Middle Last		4. DATE OF DEATH <u>Aug. 31</u> 19 <u>61</u> Month Day Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1878</u> <u>83</u> yrs. Months Days Hours Min.	
9. AGE (In years, last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Lochenauer</u>		14. MOTHER'S MAIDEN NAME <u>Lolly Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-2388</u>	
17. INFORMANT <u>Agnes L. Morton</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> (b) <u>Arterio-sclerotic Cardio Vascular Disease</u> (c) <u>Age</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma Bronchial</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1958</u> , to <u>8/31, 1961</u> , that (I) (we) last saw the deceased alive on <u>8/14, 1961</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Sr.</u>		22b. ADDRESS <u>460 S EDMONDSON AVE</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>CLIFF RATLIFE, SR.</u>		22d. ADDRESS <u>460 S EDMONDSON AVE</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial 9/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
23d. LOCATION (City, town or county) <u>Balto. Co. Md.</u>		23e. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mark Spitt + Son</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



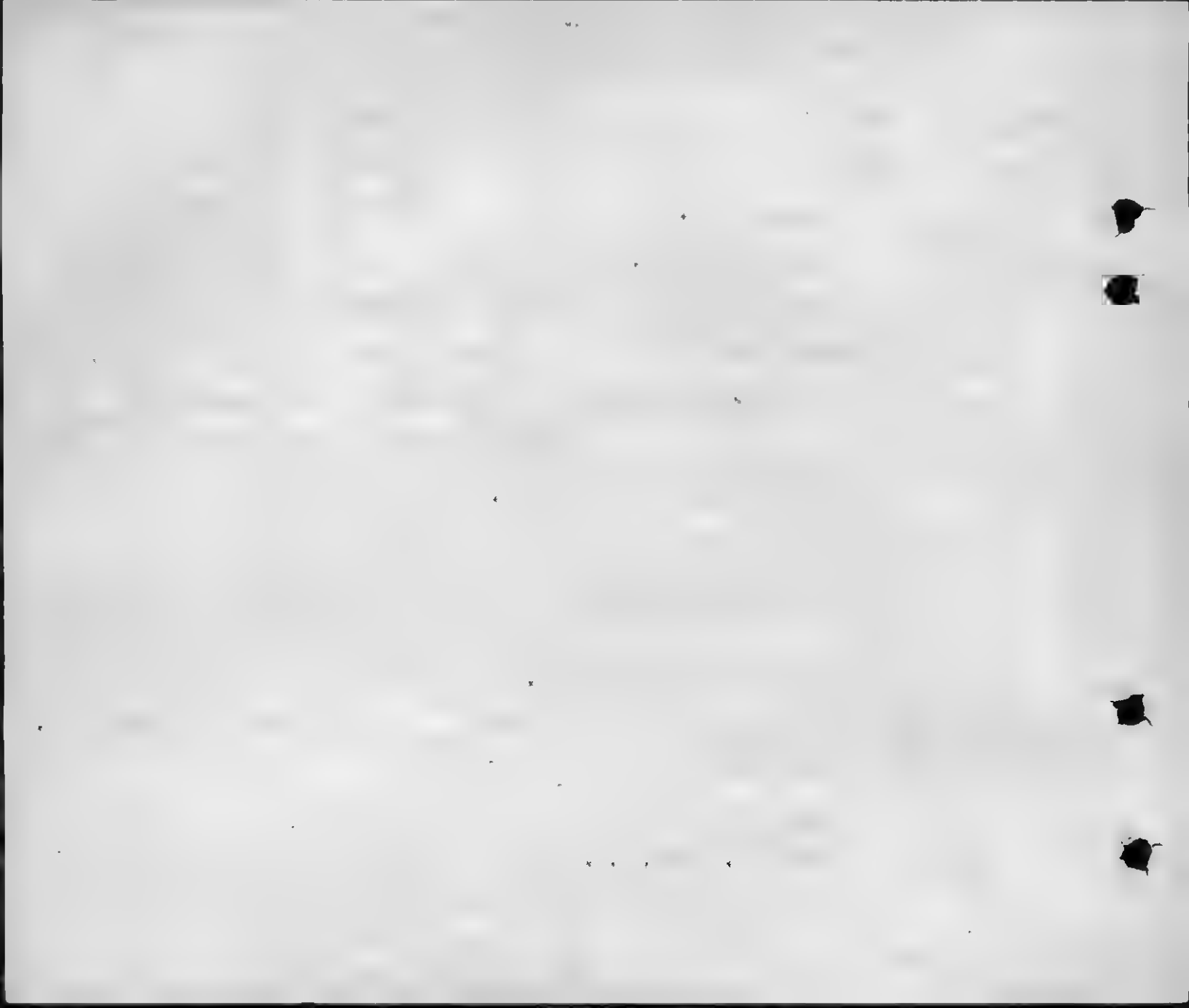
18 FOR STATE HEALTH DEPT

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08873									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fullerton					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fullerton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4940 Hazelwood Ave.					d. STREET ADDRESS 4940 Hazelwood Avenue				
3. NAME OF DECEASED (Type or print) CLARENCE G. LUKEN					4. DATE OF DEATH August 26 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 30-1882		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Accountant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME August William Luken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. A. Wm. Luken		Address 4932 Hazelwood		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head. 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head.							
20c. TIME OF INJURY Hour 8:00 p.m. Month, Day, Year 8/26 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Fullerton		(County) Baltimore	
20g. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-30-61		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		22d. LOCATION (City, town, or country) BALTO Md		(State)	
23. FUNERAL DIRECTOR Leonard J. Luck		ADDRESS 5305 Hayford A		24a. REC'D BY REGISTRAR 29 61		24b. REGISTRAR'S SIGNATURE Arthur S. Finner		DATE 8/27/61	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

M

Item 18-21 Film 293 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
8882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08876															
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bridge #3, Warren Road				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3204 Second Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First DORIS Middle MARGARET Last MACAULEY				4. DATE OF DEATH Month Found Day August Year 2				9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH Aug. 10, 1925			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary Johns Hopkins Hosp.				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George H. Macauley Sr.				14. MOTHER'S MAIDEN NAME Emma D. Dietz				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. George H. Macauley, Jr.				Address same				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 975X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Found drowned								20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 X 7/30 19 61			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water				20f. (City or town) Baltimore				20g. (County) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Howard G. Shaub				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8/2/61			
EXAMINER'S NAME (Type) Howard G. Shaub, M.D.				Address (Street, city, town, or county) Baltimore, Maryland				22a. BURIAL, CREMAT OR REMOVAL (Specify) Burial				22b. DATE THEREOF 8/4/61			
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park				22d. LOCATION (City, town, or country) Baltimore, Maryland				23. FUNERAL DIRECTOR Leonard J. Ruck				24. REC'D BY REGISTRAR 5305 Harford Road #14			
24a. DATE AUG 4 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Harris											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

M

I

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
8884									
CERTIFICATE OF DEATH									
08875									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5116 Shelbourne Road					e. STREET ADDRESS 5116 Shelbourne Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle B. Last Maxwell, Sr.					4. DATE OF DEATH Month August Day 21 Year 1961				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1890		9. AGE (In years last birthday) 70 yrs	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Rome Theatrical Co		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Maxwell					14. MOTHER'S MAIDEN NAME Annie Barlow				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. XXXX Bertha V. Maxwell		17. INFORMANT 5116 Shelbourne Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma 151 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.									
22a. SIGNATURE James Frederick, M. D.					22b. DATE SIGNED Francis Avenue				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8/23/61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard					ADDRESS 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR 22 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hinkle



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

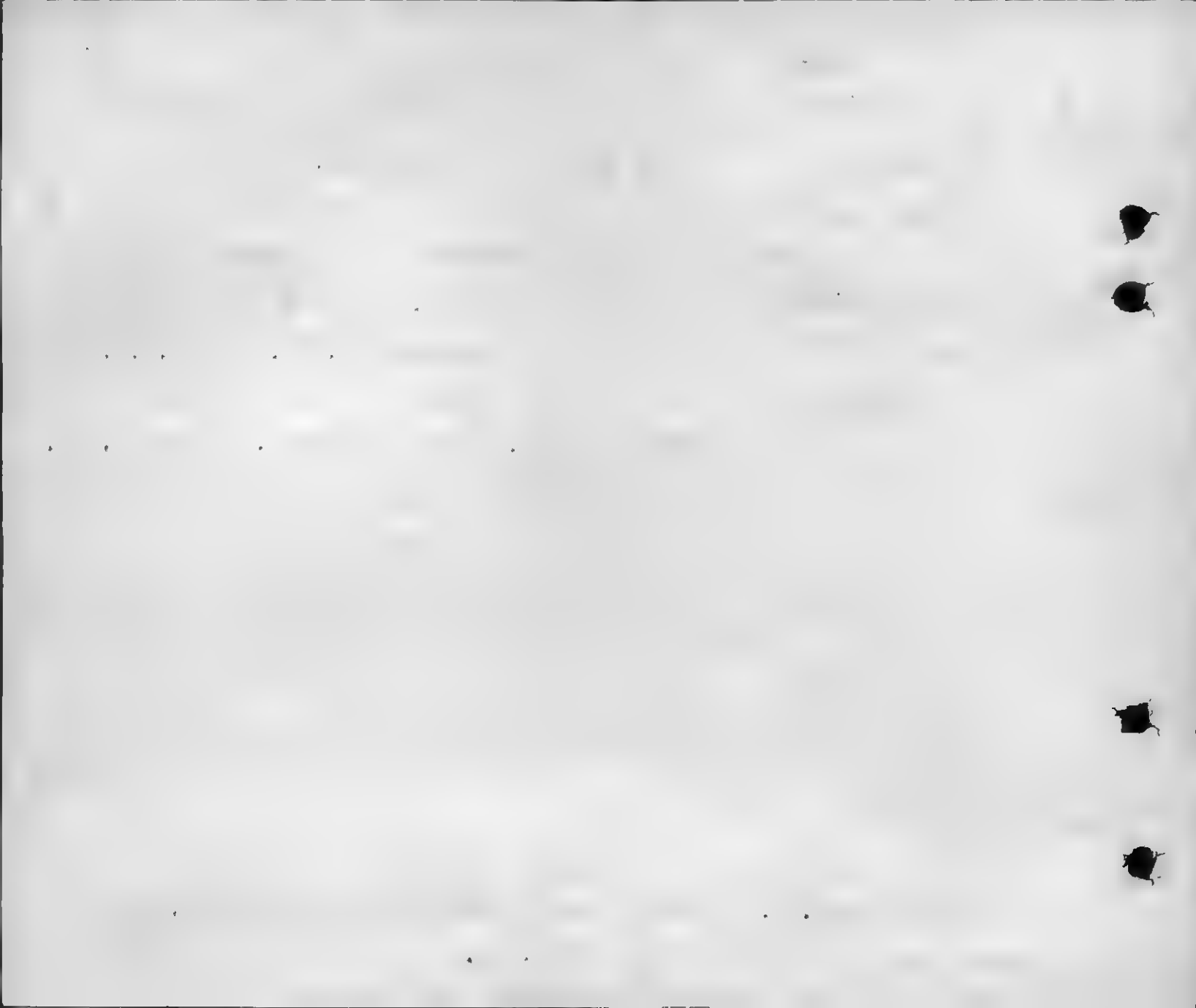
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

8885

118877

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived; if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN MD 65 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cockeys Mill Road		d. STREET ADDRESS Cockeys Mill Road	
3. NAME OF DECEASED (Type or print) First Mary Ellen McCauley		4. DATE OF DEATH August 9, 1961	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH August 27, 1895		9. AGE (In years, last birthday) 65 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) Reisterstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris Uhler		14. MOTHER'S MAIDEN NAME Emma Gore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marion Zimmerman, Finksburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199X IMMEDIATE CAUSE (a) Carcinomatosis, intra abdominal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that (I) (this hospital) attended the deceased from 7-30-51 , 19.., to 8-9-61 , 19....., that (I) (we) last saw the deceased alive on 8-8-61 , 19....., and that death occurred at 3 A M, from the causes and on the date stated above.			
22a. SIGNATURE A. Z. Caples			
22b. DATE SIGNED 8-10-61			
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1961	
23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		23d. LOCATION (City, town or county) (State) Reisterstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Eckhardt		25a. REC'D BY REGISTRAR Aug 11 '61	
ADDRESS Owings Mills, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

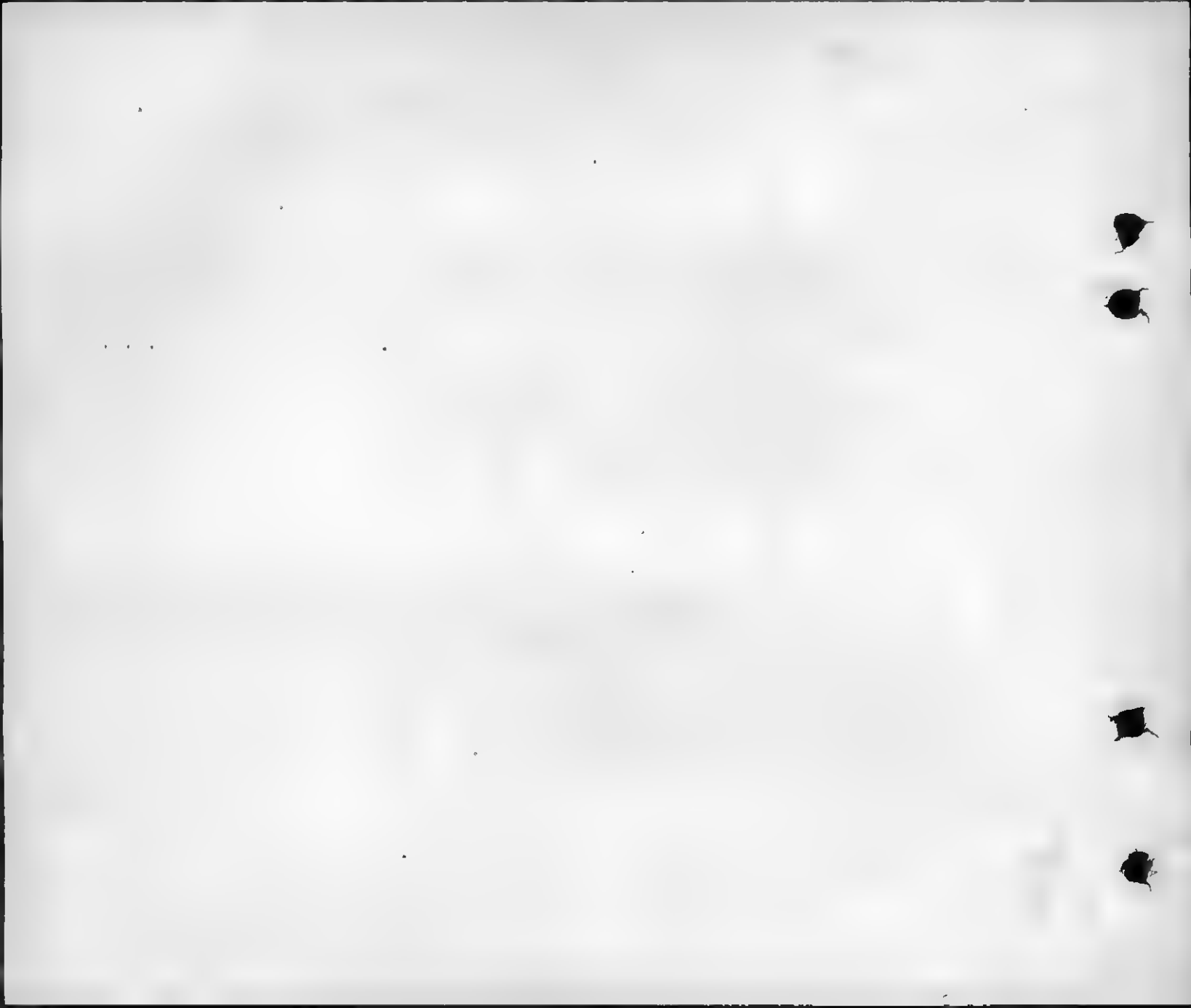
VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8885

08878

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Mc Clain		4. DATE OF DEATH Month 8 Day 17 Year 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1883
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mc Clain		14. MOTHER'S MAIDEN NAME Catherine Noel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO ADAMS - STOKES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ASCD. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 19 60 to 8/17 , 19 61 , that (I) (we) last saw the deceased alive on 8/16 , 19 61 , and that death occurred at 7:24 AM , from the causes and on the date stated above			
22a. SIGNATURE D. Mahan M.D.		22b. DATE SIGNED 8/18/61	
22c. PHYSICIAN'S NAME (Type) D. Mahan M.D.		22d. ADDRESS 602 E. Joppa Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/18/61		23b. DATE THEREOF 8/18/61	
23c. NAME OF CEMETERY OR CREMATORY New Cal. Federal		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank J. Lacey		25a. REC'D BY REGISTRAR 8/18/61	
ADDRESS 814 W 36th St		25b. REGISTRAR'S SIGNATURE Charles J. Knecht	



8887

CERTIFICATE OF DEATH

Reg. Dist. No.

68879

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2421 Wythe Ave.		d. STREET ADDRESS 2421 Wythe Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Blair Last Medlin		4. DATE OF DEATH Month August Day 7 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1909
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John I. Medlin		14. MOTHER'S MAIDEN NAME Nettie Jane Bees	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 465-12-6269	
17. INFORMANT Mrs. Julia Medlin, 2421 Wythe Ave. Balto. 19		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from November, 1960 to August 7, 1961 , that I last saw the deceased alive on August 7, 1961 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John V. Conway		ADDRESS (Street, city or town, state) _____ DATE SIGNED 8-8-61	
PHYSICIAN'S NAME (Type) _____		M.D. _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 9, 1961	22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge	22d. LOCATION (City, town, or county) Dorsey, Md. (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.		24a. REC'D BY REGISTRAR AUG 9 '61	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After the funeral director has been notified, the certificate should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4

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15M 9/59

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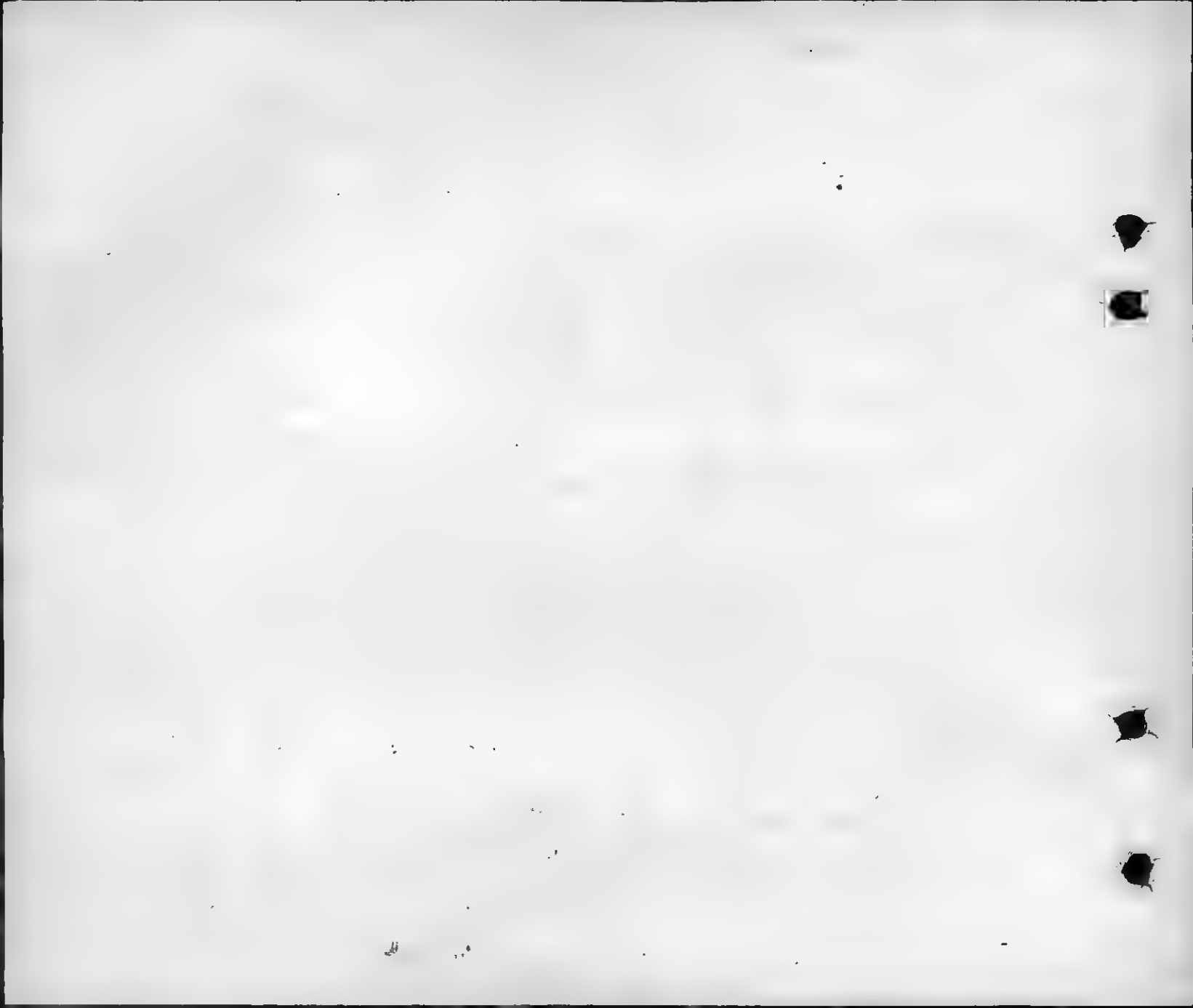
8888

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08880

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3433 Philips Drive		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 3433 Philips Drive 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Louis Minch First Middle Last 4. DATE OF DEATH August 20, 1961 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec 25, 1893 9. AGE (In years last birthday) 67 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive 11. BIRTHPLACE (State or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME deceased - unknown 14. MOTHER'S MAIDEN NAME deceased - unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT Mrs. Theresa Minch-- Same Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 527-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/6 19 61 to 8/20 19 61 , that (I) (we) last saw the deceased alive on 8/20 19 61 , and that death occurred at 6 M, from the causes and on the date stated above 22a. SIGNATURE Josephine M. H. H. H. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 8/22/61 23c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno Cong. 23d. LOCATION (City, town, or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC 6010 Reist. Rd. Balto Md ADDRESS 25a. REC'D BY REGISTRAR AUG 28 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8889

68881

(M)

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. 19yr5mth7dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruby Middle Morgan Last Morgan 4. DATE OF DEATH Month August Day 15 Year 1961		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 27, 1894 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 6 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Levi Morgan 14. MOTHER'S MAIDEN NAME Anna Gaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiac failure (c) Arteriosclerotic cardiovascular disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Hour a.m. 12:45 p.m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from March 3, 1942 to Aug. 15, 1961 that (I) (we) last saw the deceased alive on Aug. 15, 1961 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Stella Wachler 22c. PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		22b. DATE SIGNED 8-15-61 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried 23b. DATE THEREOF Aug. 18, 1961 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 23d. LOCATION (City, town or county) (State) Frederick Md.		25a. REC'D BY REGISTRAR Waltz Funeral Home DATE AUG 18 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. If the death certificate is not signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

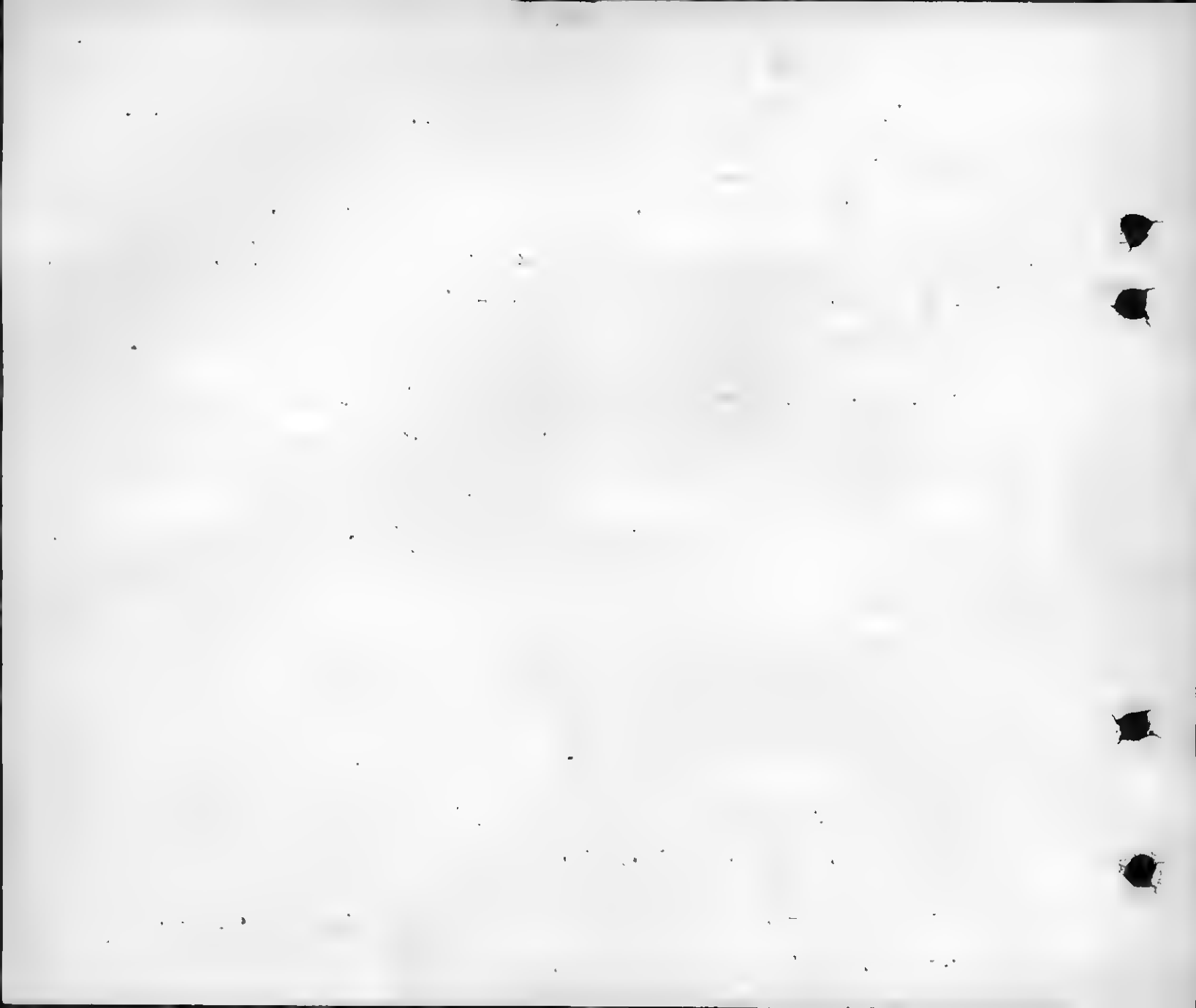
CERTIFICATE OF DEATH

Reg. Dist. No. 18882

2890

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>225 Overbrook Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>Bertha</i> Middle <i>Maeller</i> Last <i>Maeller</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>10</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-2-1889</i>
9. AGE (In years, lost birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Christian Mueller</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Mareck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>MR William Graham</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Infarction</i> 463 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Phlebotomy in Rt. Suprarenal V.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 30, 1960</i> to <i>Aug 10, 1961</i> , that I last saw the deceased alive on <i>Aug 9, 1961</i> , and that death occurred at <i>8:15 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles Carr, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>6201 York Rd</i> DATE SIGNED <i>8/14/61</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Charles Carr, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>8-14-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. RECEIVED BY REGISTRAR <i>AUG 14 '61</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

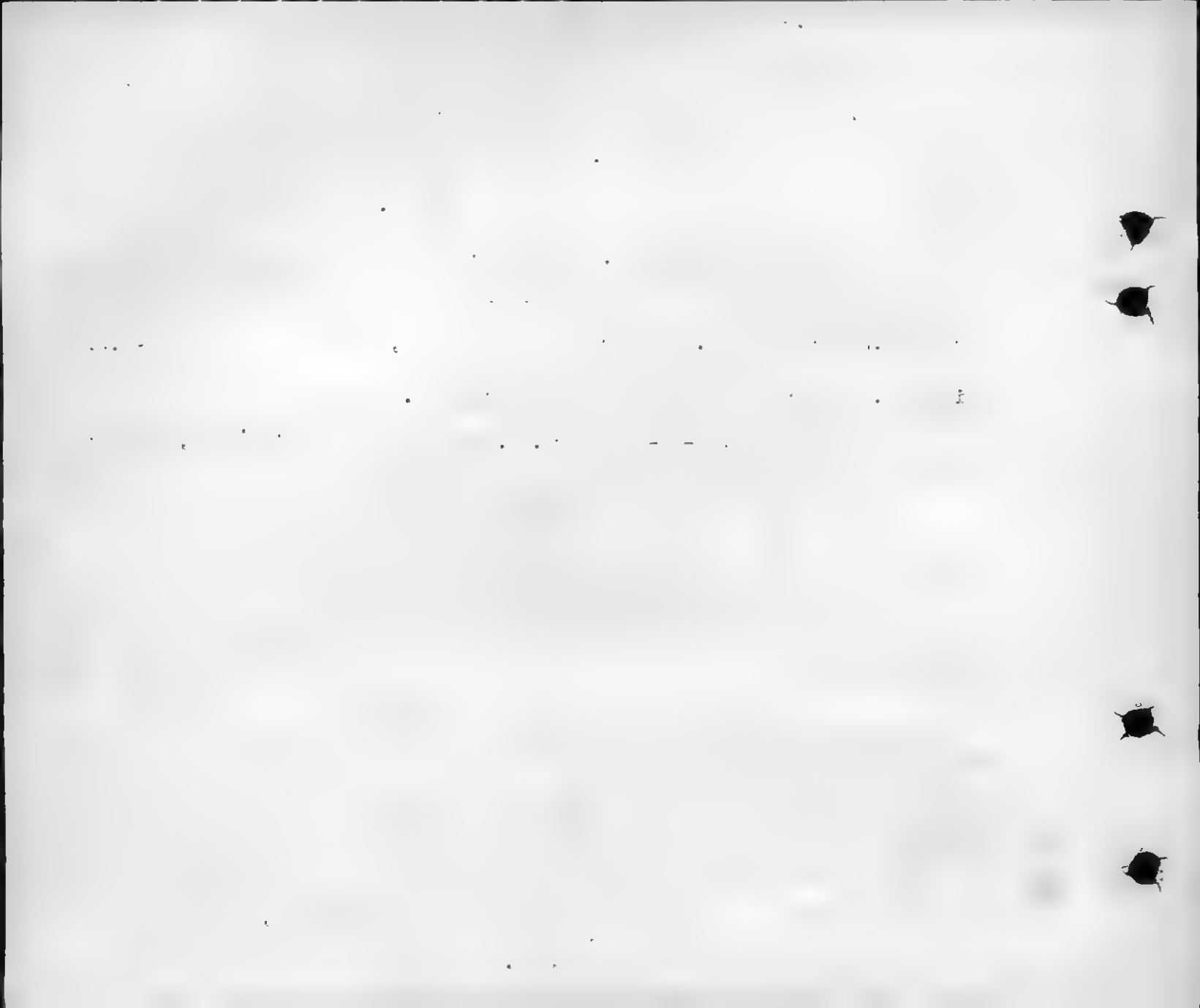
8891

18883

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7				c. LENGTH OF STAY IN lb 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2306 N. Rolling Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Mumford				4. DATE OF DEATH Month August Day 21 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-25-1887	
9. AGE (In years lost birthday) 74 yrs		10. UNDER 1 YEAR Months 7 Days 4 Hours 15 Min.		11. UNDER 24 HRS Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sup. Starter				10b. KIND OF BUSINESS OR INDUSTRY Md. Race Track		11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland	
13. FATHER'S NAME Sidney J. Mumford				14. MOTHER'S MAIDEN NAME Sophia E. McKee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-03-6397		17. INFORMANT Mrs. N. Lee Mumford Address 2306 N. Rolling Road Baltimore 7, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis - Cardiac infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO 24/100 (c) Extracerebral Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15 19 61 to 8/21 19 61 that (I) (we) last saw the deceased alive on 8/11 19 61 and that death occurred at 8/21 M, from the causes and on the date stated above							
22a. SIGNATURE Edwin L. Pierpont M.D.				22b. DATE SIGNED 8/21/61			
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				22d. ADDRESS 2244 LIBERTY AVE. BALTIMORE 1, MD.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James J. Jones				25a. REC'D BY REGISTRAR DATE AUG 24 '61		25b. REGISTRAR'S SIGNATURE William E. Hanna	

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CERTIFICATE OF DEATH

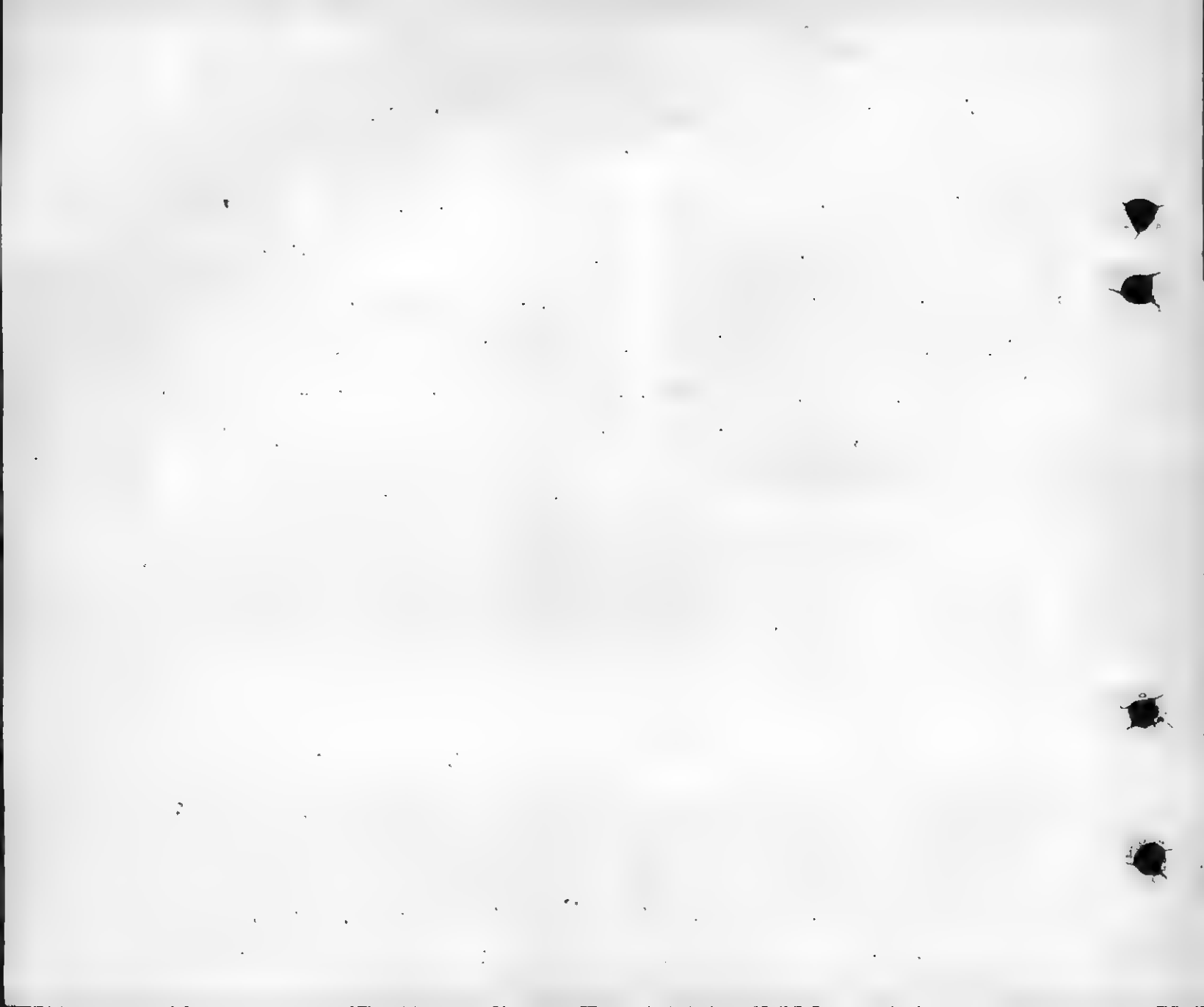
Reg. Dist. No. 08884

8892

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 GLENMORE AVE.		d. STREET ADDRESS 113 GLENMORE AVE	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN F. MURPHY		4. DATE OF DEATH Month Day Year AUGUST 20 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 18 1899
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL J. MURPHY		14. MOTHER'S MAIDEN NAME JENNIE PEIFFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO 216-01-7216	
17. INFORMANT MRS. MABEL E. MURPHY		Address 113 GLENMORE AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Complete heart block. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (last). (b) Coronary Disease - chronic myocardial infarction 1954 DUE TO (c) Atherosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to Aug 20, 1961 , that I last saw the deceased alive on August 19, 1961 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6014 Edmondson Ave Balto 28, Md 8/14/61 DATE SIGNED J. Nelson McFay			
ACTUAL SIGNATURE J. Nelson McFay		M.D. 6014 Edmondson Ave Balto 28, Md 8/14/61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 24 1961	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G. TRUMAN SCHWAB		24a. REC'D BY REGISTRAR 3512 FREDERICK AVE DATE AUG 24 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

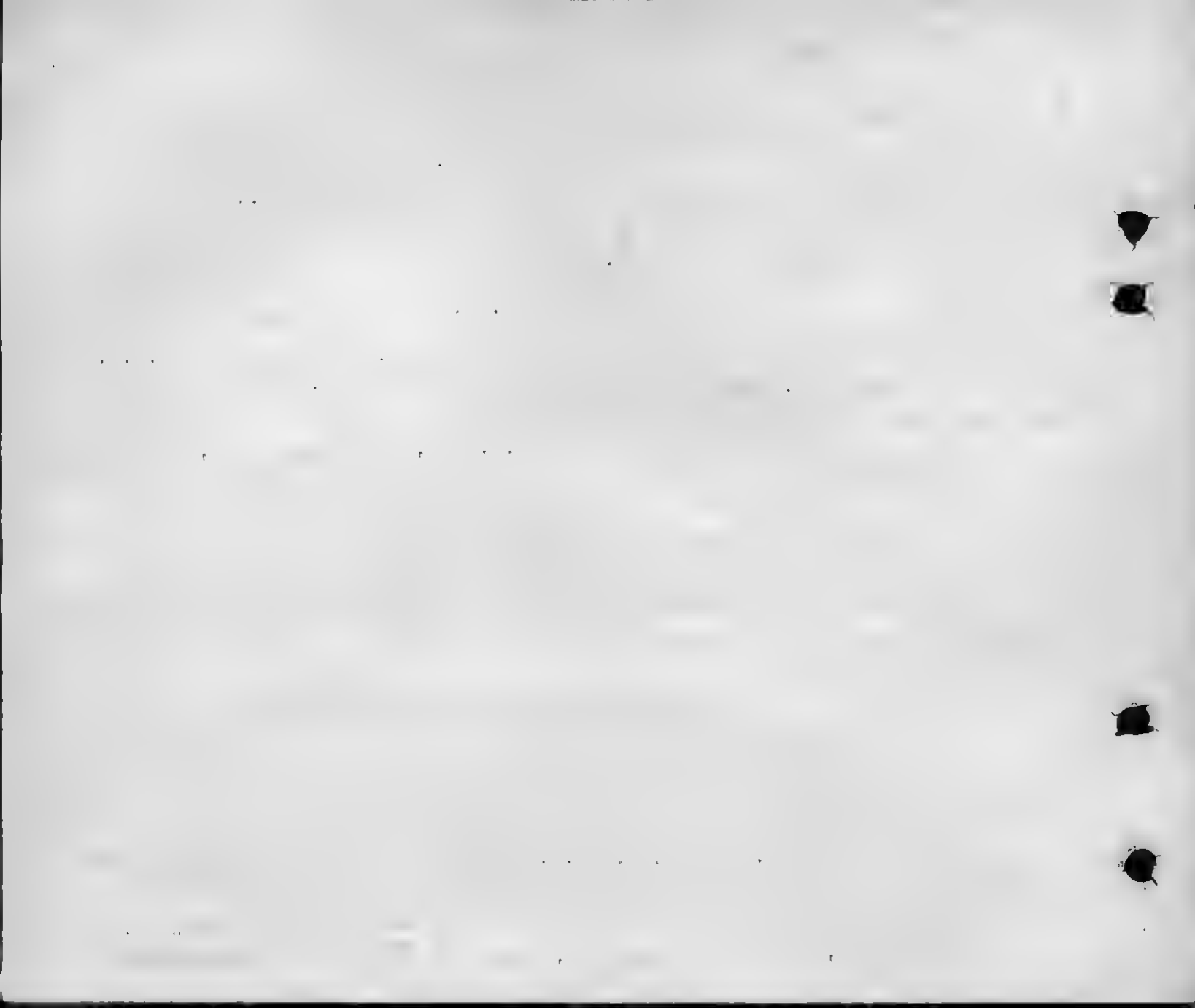
8893

08885

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 c. LENGTH OF STAY IN 15 MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armcast Nursing Home 812 Regester Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution's Residence before admission) a. STATE Maryland b. COUNTY Baltimore 18 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warrington Apts., 3908 North Charles St d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charlotte J. Oliver		4. DATE OF DEATH August 18 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 22 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick D. Hall	
14. MOTHER'S MAIDEN NAME Katherine Mumma		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Fred. E. Hall, 121 Gothard Road, Lutherville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage DUE TO (b) Arteriosclerosis cardio-vascular DUE TO (c) Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 17, 1961 to Aug 18, 1961 , that (I) (we) last saw the deceased alive on Aug 17, 1961 , and that death occurred at 7:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred G. Ossman, Jr.		22b. DATE SIGNED 8-20-61	
22c. PHYSICIAN'S NAME (Type) Alfred G. Ossman, Jr. M.D.		22d. ADDRESS 216 East University Parkway, Zone 18	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-21-61	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery	23d. LOCATION (City, town or county) (State) Baltimore
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		25a. REC'D BY REGISTRAR AUG 22 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it is complete. It should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is complete. It should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

8894

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08886

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY P.O.</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>JOHNNYCAKE RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> d. STREET ADDRESS <u>137 Cherrydel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN L. OPEL</u> First Middle Last 4. DATE OF DEATH <u>AUG 1 1961</u> Month Day Year		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>10-2-1889</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmon-Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>August Opel</u> 14. MOTHER'S MARRIED NAME <u>Elizabeth Klein</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>4-1-1</u> 17. INFORMANT <u>Mrs Mildred Smith - White Marsh - Mds</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>150.0</u> DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic carcinoma</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/11/61</u> , 19 <u>61</u> , to <u>8/1/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/11/61</u> , 19 <u>61</u> , and that death occurred at <u>1961</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Milton Schlenoff</u> M.D.		22b. DATE SIGNED <u>Balto Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>Milton Schlenoff</u>		22d. ADDRESS <u>6410 Windsor Mill Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Balt. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. M. Matt - Son</u> ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR <u>AUG 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

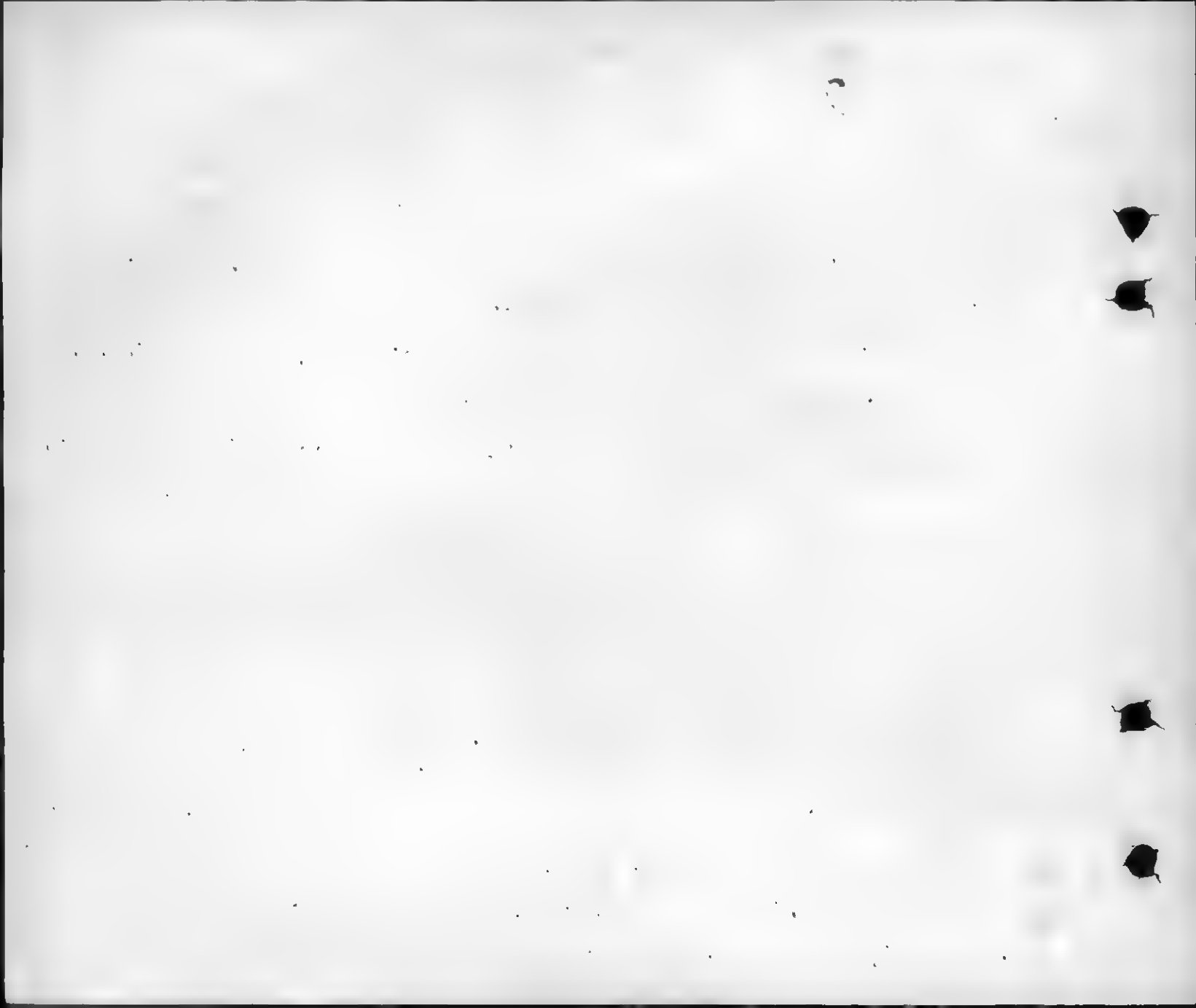
08882

8895

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 Belfast Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Julia</u> Middle <u>Agatha</u> Last <u>O'Sullivan</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7th</u> Year <u>19 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Reardon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Riordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service))		16. SOCIAL SECURITY NO.	
INFORMANT <u>Mrs. Catherine Eckert</u>		Address <u>28 Belfast Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardio Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1956</u> to <u>Aug 7th 1961</u> , that I last saw the deceased alive on <u>Aug 7th 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M. K. Quinn</u> M.D. <u>1927 YORK RD, TIMONIUM, 8/8/61</u>			
ACTUAL SIGNATURE <u>M. KEVIN QUINN</u>		PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/11/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

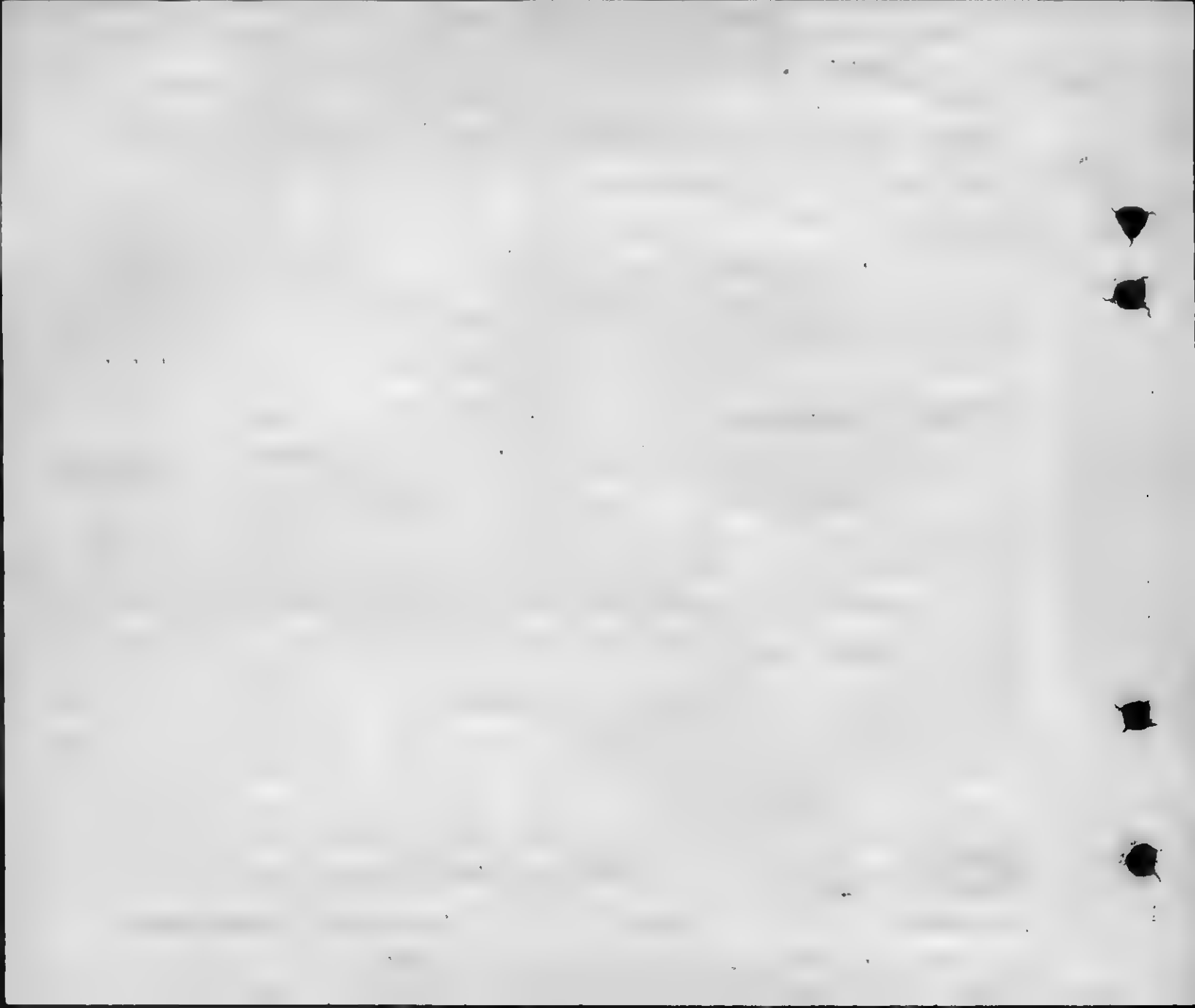
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If possible, it should be executed at the funeral director's office. Page 1, 2, and 3 of this certificate should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8895

118888

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2818 Glendale Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2818 Glendale Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Peter</u> First Middle Last 4. DATE OF DEATH <u>August 23rd</u> 19 <u>67</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 5, 1889</u> 9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Cook</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Greece</u> 11. BIRTHPLACE (State or foreign country) <u>Greece</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Phillips</u> 14. MOTHER'S MAIDEN NAME <u>Diane ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>051-74-0141</u> 16. SOCIAL SECURITY NO. <u>051-74-0141</u> 17. INFORMANT <u>Mrs. Bessie Phillips</u> Address <u>same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerotic</u> (c) <u>Cardiovascular Disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>undet.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-24-67</u> Address (Street, city, town, or country)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/26/67</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cem.</u> 22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>		23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Road #14</u> ADDRESS 24a. REC'D BY REGISTRAR <u>DATE AUG 25 '67</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

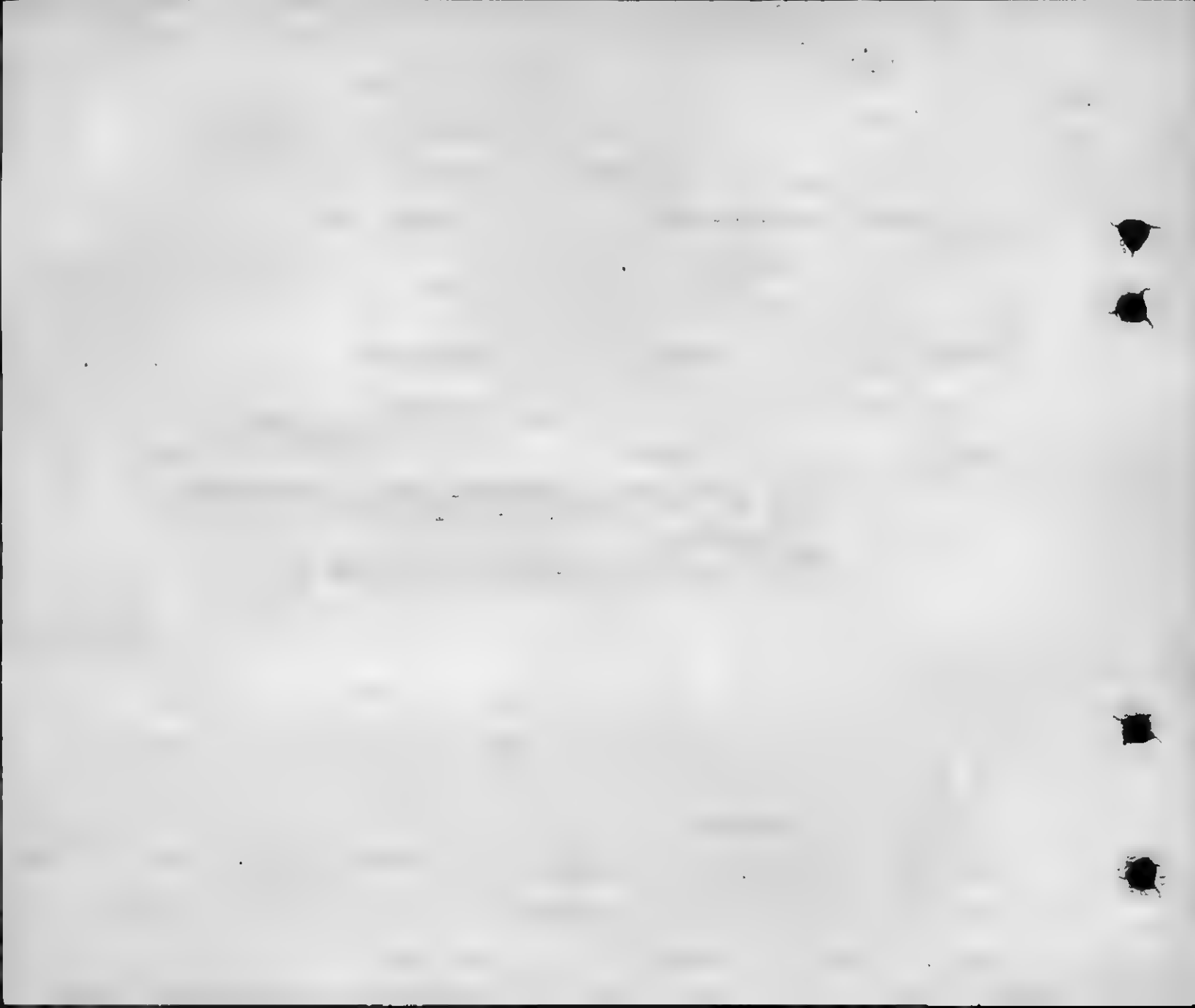


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
28897											
Item 23 Film C294 9/5/61 mh											
08889											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN lb 73 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1923 Brunt Street					
3. NAME OF DECEASED (Type or print) ROBERT A. POWELL						4. DATE OF DEATH Month August Day 28 Year 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 6, 1899		9. AGE (In years last birthday) 62 yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Morgue attendant						10b. KIND OF BUSINESS OR INDUSTRY Pathology					
11. BIRTHPLACE (County & State, or foreign country) Mount Washington, Maryland						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William Powell						14. MOTHER'S MAIDEN NAME Ella Dutton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I						16. SOCIAL SECURITY NO 212-18-0865					
17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG WITH METASTASIS TO LUMBAR VERTEBRAE, 4-5, LIVER, PERICARDIUM, HILAR LYMPH NODES Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. (b) XXXX (c) XXXX BILATERAL PYLONEPHRITIS AND HYDRONEPHROSIS					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS UNKNOWN					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (X) (th) (s) hospital attended the deceased from June 16, 1961 to August 28, 1961 , that (M) (we) last saw the deceased alive on August 28, 1961 , and that death occurred at P.M. from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo						22b. DATE SIGNED 8/29/61					
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.						22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THERE Sept. 1, 1961					
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery						23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Ludlow H. Carroll						25a. REC'D BY REGISTRAR SEP 1 '61					
25b. REGISTRAR'S SIGNATURE Charles S. Hanna											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

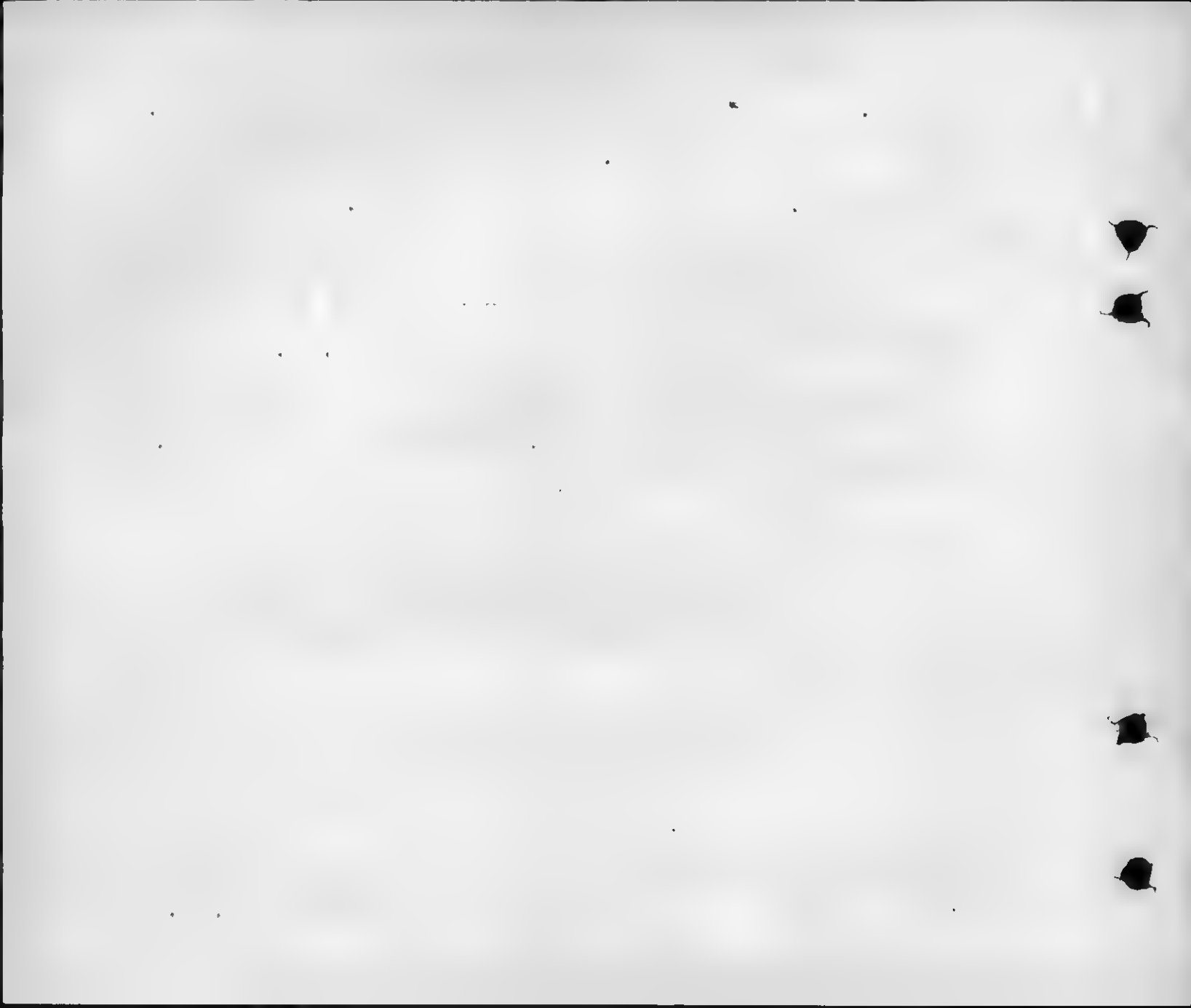
2898

CERTIFICATE OF DEATH

Reg. Dist. No.

08850

1. PLACE OF DEATH a. COUNTY Balte. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balte.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall				c. LENGTH OF STAY IN lb 25 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9525 Belair Rd.				d. STREET ADDRESS 9529 Belair Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edith Jean Preble First Middle Last				4. DATE OF DEATH Aug. 1 19 61 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1897		9. AGE (In years, lost birthday) 63 yrs.	10. UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry Wolfes				14. MOTHER'S MAIDEN NAME Francis Ellen Bodine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address J. Douglas Preble 9525 Belair Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) Arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 mo. 2 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive failure controlled							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 1960 to Aug. 1961 , that I last saw the deceased alive on Aug 1 1961 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.				ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED Aug. 1, 1961			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-3-61	22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lassahn J. Howell 7401 Belair Rd. Balto. Md.				24a. REC'D BY REGISTRAR DATE AUG 4 '61		24b. REGISTRAR'S SIGNATURE C. S. King	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
Baltimore				Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
Dundalk				Baltimore			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
7452 German Hill Road				7452 German Hill Road			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
GEORGE C. PRETTYMAN				August 18, 19 61			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				June 3, 1890			
9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
71 yrs.				Carpenter			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Pennsylvania				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Prettyman				Ellen Newman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
No.				191-05-1009			
17. INFORMANT				Address			
Mrs. Orpha Prettyman				7452 German Hill Road.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				A-S-C-V-T disease			
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)			
DUE TO				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
Ca of Liver				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
M.B. Davis, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial				8/21/61			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
Meadow Ridge Cemetery				Elkridge, Md.			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
Ullrich Funeral Home Dundalk, Md.				24b. REGISTRAR'S SIGNATURE			
				AUG 23 '61			

8/19/61

Arthur L. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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8900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08892

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EXXMAN Catonsville c. LENGTH OF STAY IN 1b 20 Shady Nook Avenue d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Shady Nook Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 20 Shady Nook Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen C. Pruitt (Also Helen B. Pruitt)		4. DATE OF DEATH August 7, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1913
9. AGE (In years last birthday) 47 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Montgomery Ward's	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John E. Bothmer		14. MOTHER'S MAIDEN NAME Mary Steinwedel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-09-5256	
17. INFORMANT Wilbur R. Pruitt		Address 20 Shady Nook Ave. #28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Returned dissecting aneurysm of abdominal aorta DUE TO Arterio-sclerosis DUE TO Diabetes mellitus DUE TO Pyloric aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o m p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 31, 1961 , to Aug 7, 1961 , that (I) (we) last saw the deceased alive on Aug 2, 1961 , and that death occurred at 5:30 M, from the causes and on the date stated above			
22a. SIGNATURE H. A. E. Calas		22b. DATE 8/7/61	
22c. PHYSICIAN'S NAME (Type) H. A. E. Calas, M. D.		22d. ADDRESS 4 N. Fulton Ave., Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/9/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR AUG 9 '61	
ADDRESS 4107 Wilkens Avenue #29		25b. REGISTRAR'S SIGNATURE Charles S. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician complete the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2901

Items 2 & 7 Film 292 8/11/61

08893

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in lb 4mth23dys		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		A.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick Md. Pasadena		f. STREET ADDRESS Galvest Co. Nursing Home		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Albert		First		Middle		Last		4. DATE OF DEATH August 1 1961		Day Month Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1876		9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? Sweden					
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from March 8 1961 to Aug. 1 1961 that (I) (we) last saw the deceased alive on Aug. 1 1961 , and that death occurred at 3:25 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 8-1-61		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
				DATE AUG 7 '61		William S. Thomas					

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8902

118894

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kelly Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville d. STREET ADDRESS Kelley Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sophia Jane Randall First Middle Last		4. DATE OF DEATH August 27, 19 61 Month Day Year	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Dec. 30, 1862 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 98 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Tracey		14. MOTHER'S MAIDEN NAME Annie E. Morfett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Sophia J. Kelley Address Lutherville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) myocardial Chronic Decompensation DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. General arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3P 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-30 , to 8-27-61 , that (I) () last saw the deceased alive on 8-27-1961 , and that death occurred at 3P , from the causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 8-28-61	
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD.		22d. ADDRESS Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30, 61	
23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		23d. LOCATION (City, town or county) (State) Reisterstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		25a. REC'D BY REGISTRAR SEP 1 '61 25b. REGISTRAR'S SIGNATURE Christian S. Kraus	

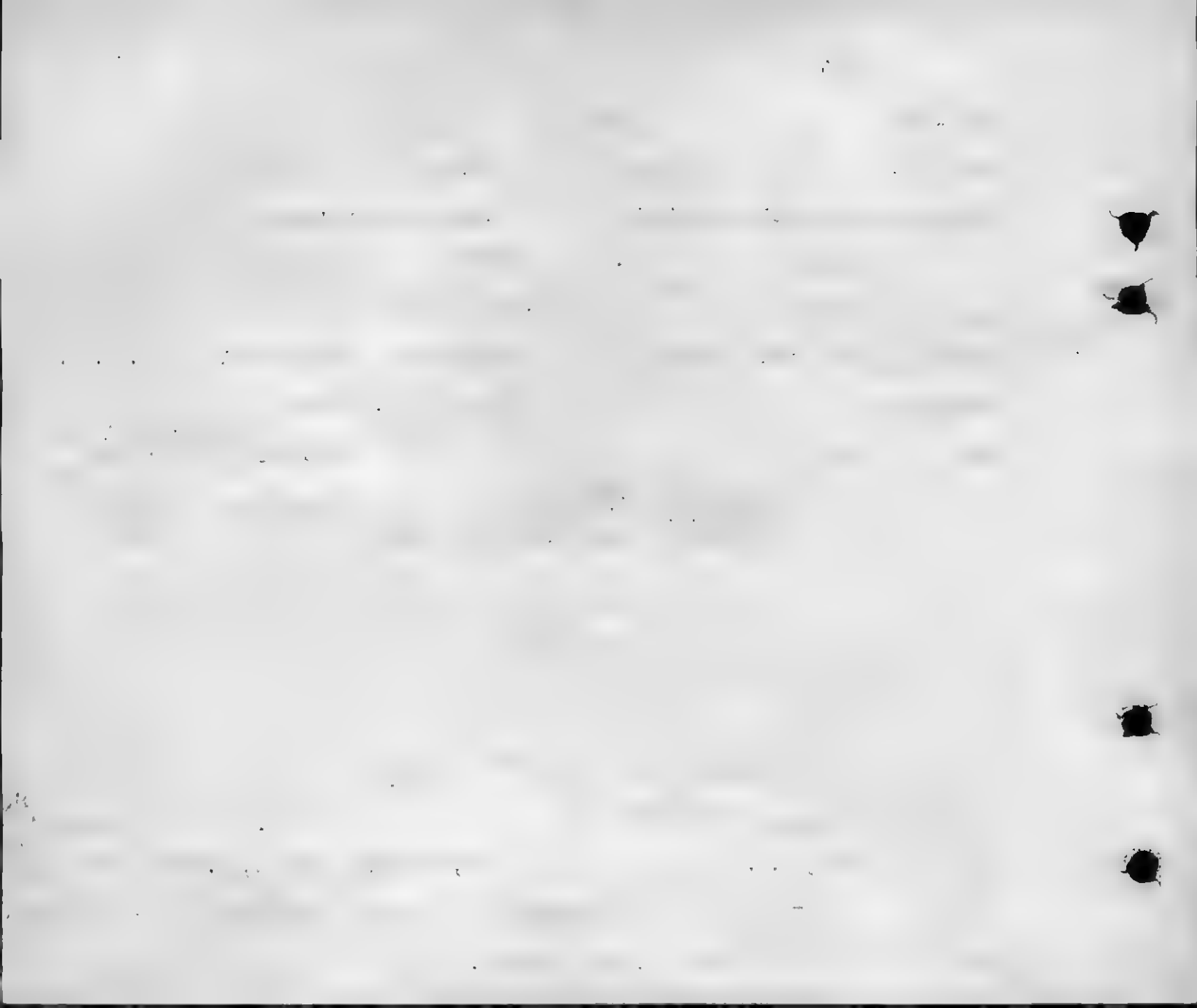


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital director may be relieved of this duty if the certificate is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital director may be relieved of this duty if the certificate is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8903 CERTIFICATE OF DEATH 08895

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2414 Madison Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM H. REASON		4. DATE OF DEATH Month August Day 30 Year 19 61		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1897	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Man - unemployed		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Reason		14. MOTHER'S MAIDEN NAME Carolina MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Yes WW I		16. SOCIAL SECURITY NO 17. INFORMANT Clinical Records, VAH, Fort Howard Division Baltimore 18, Maryland		18. INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN 1 DAY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO (b) MYOCARDIAL INFARCTION AND INTRAMURAL THROMBOSIS DUE TO (c) PULMONARY INFARCTION, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from August 27, 19 61 to August 30, 19 61 that (we) last saw the deceased alive on August 30, 19 61 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE SEBASTIAN RUSSO, M.D.		22b. DATE 8/30/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		22e. REC'D BY REGISTRAR DATE SEP 1 '61		22f. REGISTRAR'S SIGNATURE Charles R. Law	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-61		23c. LOCATION (City, town or county) Baltimore 28, Maryland	
23d. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23e. LOCATION (City, town or county) Baltimore 28, Maryland		23f. DATE SEP 1 '61	
23g. REGISTRAR'S SIGNATURE Charles R. Law		23h. ADDRESS 802 Madison Ave., Baltimore, Md.		23i. DATE SEP 1 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital director may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital director may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital director may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

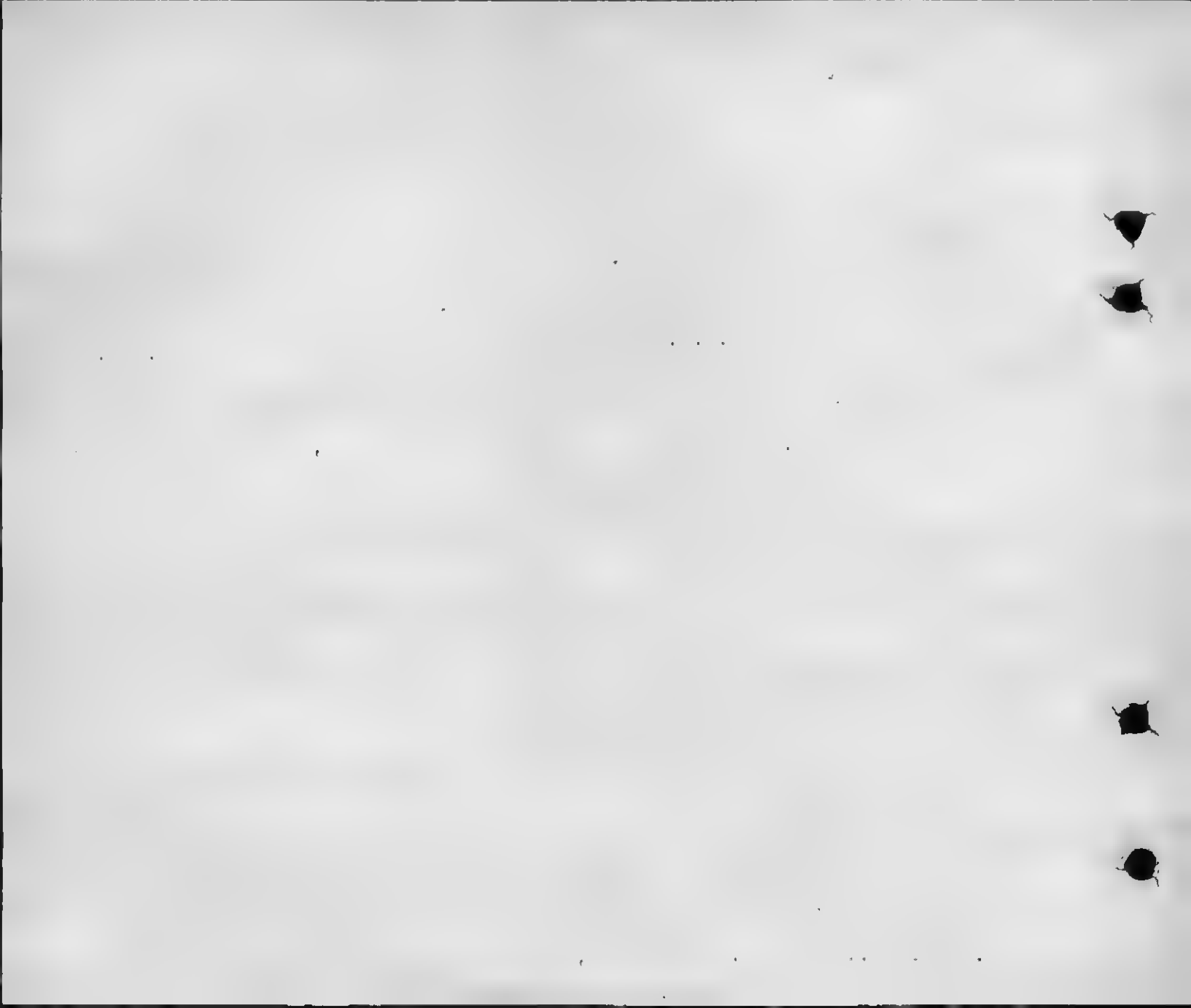
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8904

08896

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 18 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Arms Apartments Charles and 34th Streets d. STREET ADDRESS Charles and 34th Streets	
3. NAME OF DECEASED (Type or print) First Lee Middle M. Last Reely		4. DATE OF DEATH Month August Day 30 Year 1961	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY United Railway	
11. BIRTHPLACE (Country & State, or foreign country) Dayton, Howard Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Reely		14. MOTHER'S MAIDEN NAME Henrietta Nicholson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? yes (If yes give war or dates of service) N.W.I.		16. SOCIAL SECURITY NO. N.W.I.	
17. INFORMANT Mrs. Caroline Reely, Cambridge Arms Apt. 18		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE Metastatic Carcinoma of Liver (b) Carcinoma of Stomach (c) 151X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-24-1961 , to 8-30-1961 , that (I) (we) last saw the deceased alive on 8-29-1961 , and that death occurred at 2:54 M, from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallager		22b. DATE SIGNED 8-31-61	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallager M.D.		22d. ADDRESS 6207 Frederick Ave Baltimore 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-1-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		25a. REC'D BY REGISTRAR DATE SEP 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filled out by the funeral director. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118897

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salonsville</u> X	
c. LENGTH OF STAY IN lb <u>16 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>523 Academy Rd</u>		d. STREET ADDRESS <u>523 Academy Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Reid</u> Last <u>Reid</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1921</u>
9. AGE (In years last birthday) <u>39</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>14</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Sec'y Equitable Ins Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>	
11. BIRTHPLACE (State or foreign country) <u>W. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>W. S. A.</u>	
13. FATHER'S NAME <u>John Reid</u>		14. MOTHER'S MAIDEN NAME <u>Jean Muir</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>4-10-1</u>	
17. INFORMANT <u>Elzora Reid (Wife)</u>		Address <u>5550 Balto Nant Pike, Balto-28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4-20-1</u> (c) <u>Neural Calculus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8/13/61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Neural Calculus</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>Aug</u> Day <u>19</u> Year <u>1961</u> Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> 19 <u>61</u> , to <u>8/13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>61</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thos E Roche</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thos E Roche</u>		22d. ADDRESS <u>5550 Balto Nant Pike, Balto-28</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 7/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town or county) (State) <u>Balto. 7, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzel F.W. 4101 Edmondson Ave</u>		25a. REC'D BY REGISTRAR <u>Aug 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

(M)

(I)



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8905

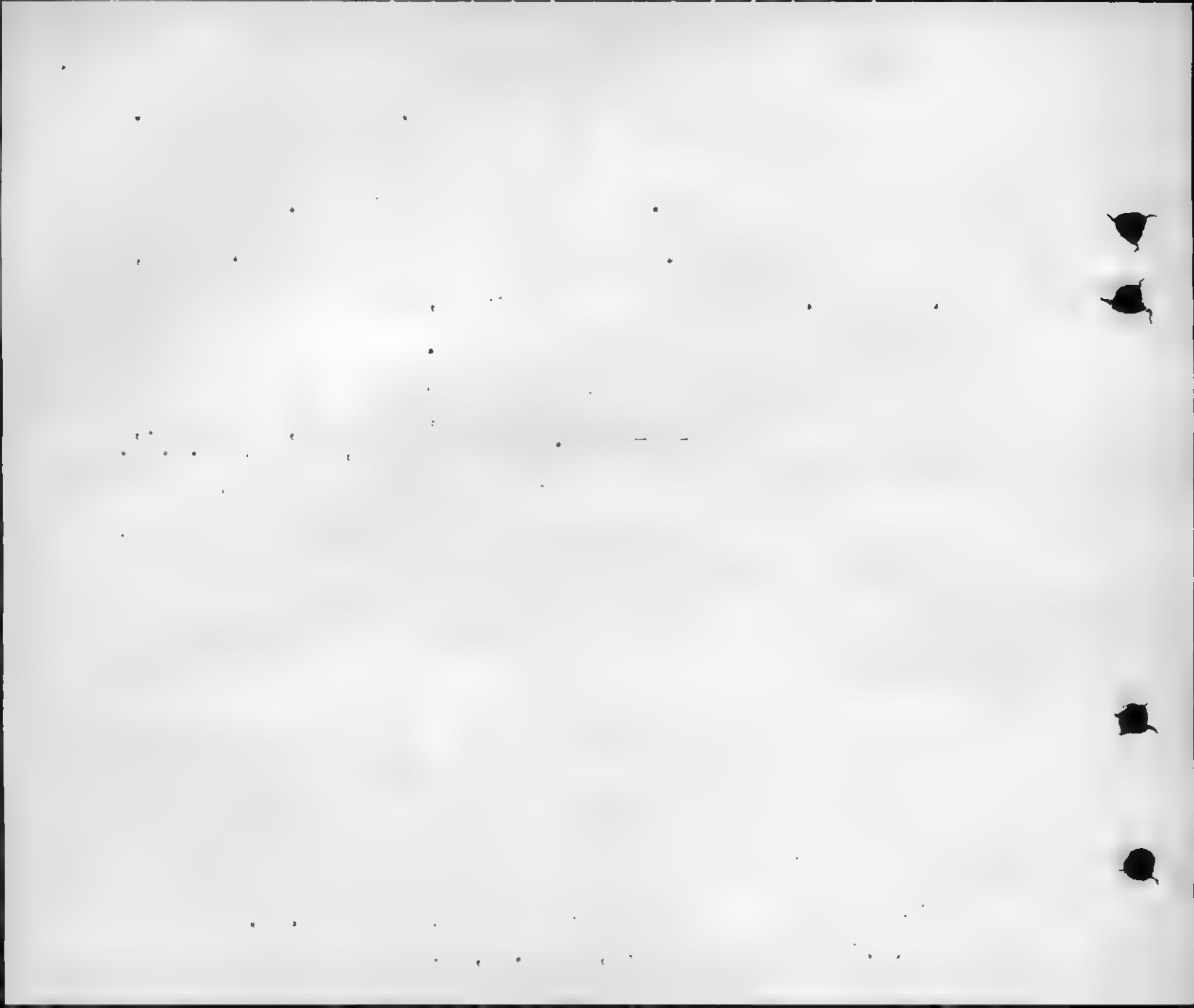
08898

Item 14 Film G292

8/16/61

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) a. STATE Ma. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5331 Dogwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary T. Reneker		4. DATE OF DEATH Month Day Year Aug. 7, 19 61	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1884
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY William Key	
11. BIRTHPLACE (State or foreign country) Ma.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Carey		14. MOTHER'S MAIDEN NAME Angeline Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO 220-30-3649A	
17. INFORMANT Mrs Lillian Efford, Box 168 A., Fairview Beach, Pasadena P.O. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153-8 DUE TO Carcinomatosis of Brain long time Primary Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 hrs 1 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/10, 1961 to 8/7, 1961 , that (I) (we) last saw the deceased alive on 8/5, 19 61 , and that death occurred 12:35 AM , from the causes and on the date stated above.			
22a. SIGNATURE Max J. Miller M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Max J. Miller, M. D.		22d. ADDRESS 1047 Ingleside Ave, Balto 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/9/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Balto, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave, Balto. 29, Md.		25a. REC'D BY REGISTRAR AUG 11 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kinn			

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

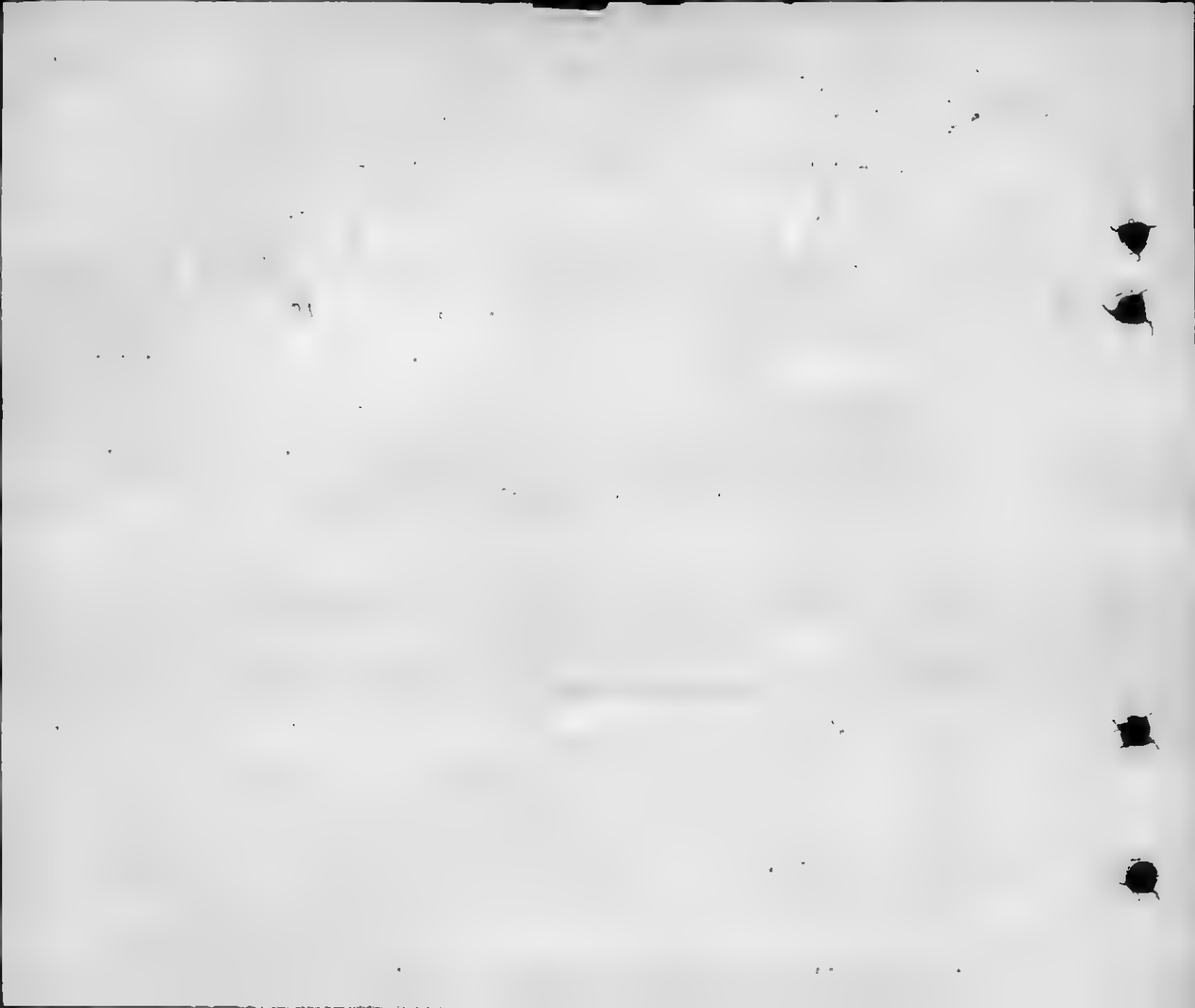
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08899

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyde - rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea - rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bottom Rd.		d. STREET ADDRESS 105 Walnut Ave.	
3. NAME OF DECEASED (Type or print) SAMUEL JESSE RHONE		4. DATE OF DEATH August 25 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 4 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. CITIZEN OF WHAT COUNTRY U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jessie Rhone		14. MOTHER'S MAIDEN NAME Adline Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. 205-03-7289	
17. INFORMANT Holcomb Funeral Home., Benton, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide and alcohol intoxication 7/23.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Inhaled auto engine fumes and drank whisky 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) road rural-Hyde Baltimore MD. 20c. TIME OF INJURY Month, Day Year 5:00 a.m. Aug. 25 19 61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road rural-Hyde Baltimore MD. 20f. (City or town) (County) (State) Baltimore MD. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/26/61 ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 22b. DATE THEREOF 8/26/61 22c. NAME OF CEMETERY OR CREMATORY Waller Cemetery 22d. LOCATION (City, town, or country) (State) Jackson Township, Pa. 23. FUNERAL DIRECTOR Wm. Cook Inc., 1217 St. Paul St. Baltimore, Md. 24a. REC'D BY REGISTRAR AUG 29 61 24b. REGISTRAR'S SIGNATURE Arthur L. Frazier	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director, after the certificate has been signed by the attending physician and completed, may fill in the remaining pages. Pages 1 and 2 should be filed with the funeral director. After the certificate is filed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

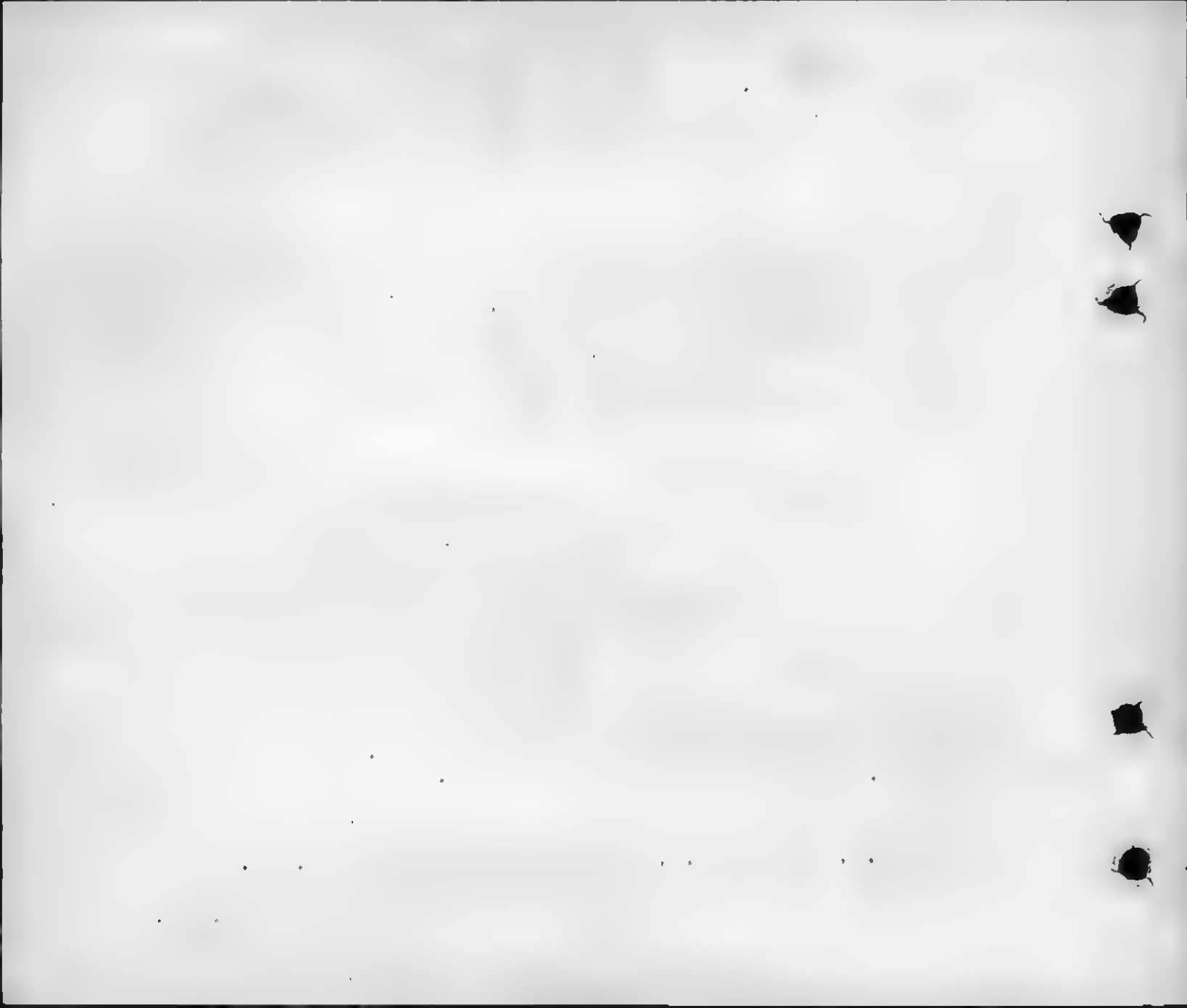
2908

CERTIFICATE OF DEATH

Reg. Dist. No.

08940

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u> <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Roberts Ave. (Catonsville Md.)</u>		d. STREET ADDRESS <u>3 Roberts Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Moses</u> Middle <u>Thomas</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Stephens (Howard Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Seawood Richardson-5500 Race Rd.</u>	
17. INFORMANT <u>Mr. Seawood Richardson-5500 Race Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio-sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12th, 1961</u> , to <u>Aug. 19th, 1961</u> , that I last saw the deceased alive on <u>Aug. 19th, 1961</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.F. Maloney</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane</u> DATE SIGNED <u>8/19/61</u>	
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>		<u>Catonsville 28. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter-3035 J. North Ave</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8909

CERTIFICATE OF DEATH

08901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY in lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Falls Road</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>Glen Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> <u>Clarence</u> <u>Rimby</u> First Middle Last				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 21, 1876</u>		9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Nunton M. Rimby</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-7026</u>			
17. INFORMANT <u>Mr. Raymond Rimby</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Chronic</u> (c) <u>Decompensating</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u> <u>Yes</u> <u>Yes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-36-1961</u> to <u>8-25-1961</u>, that (I) <u>last</u> saw the deceased alive on <u>8-23-1961</u>, and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James B. Saffell</u>		22b. DATE SIGNED <u>8-26-61</u>		22c. PHYSICIAN'S NAME (Type) <u>James B. Saffell</u>			
22d. ADDRESS <u>Reisterstown</u>		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. (City or town) <u> </u>			
22g. (County) <u> </u>		22h. (State) <u> </u>		22i. (City or town) <u> </u>			
22j. (County) <u> </u>		22k. (State) <u> </u>		22l. (City or town) <u> </u>			
22m. (County) <u> </u>		22n. (State) <u> </u>		22o. (City or town) <u> </u>			
22p. (County) <u> </u>		22q. (State) <u> </u>		22r. (City or town) <u> </u>			
22s. (County) <u> </u>		22t. (State) <u> </u>		22u. (City or town) <u> </u>			
22v. (County) <u> </u>		22w. (State) <u> </u>		22x. (City or town) <u> </u>			
22y. (County) <u> </u>		22z. (State) <u> </u>		22aa. (City or town) <u> </u>			
22ab. (County) <u> </u>		22ac. (State) <u> </u>		22ad. (City or town) <u> </u>			
22ae. (County) <u> </u>		22af. (State) <u> </u>		22ag. (City or town) <u> </u>			
22ah. (County) <u> </u>		22ai. (State) <u> </u>		22aj. (City or town) <u> </u>			
22ak. (County) <u> </u>		22al. (State) <u> </u>		22am. (City or town) <u> </u>			
22an. (County) <u> </u>		22ao. (State) <u> </u>		22ap. (City or town) <u> </u>			
22aq. (County) <u> </u>		22ar. (State) <u> </u>		22as. (City or town) <u> </u>			
22at. (County) <u> </u>		22au. (State) <u> </u>		22av. (City or town) <u> </u>			
22aw. (County) <u> </u>		22ax. (State) <u> </u>		22ay. (City or town) <u> </u>			
22az. (County) <u> </u>		22ba. (State) <u> </u>		22bb. (City or town) <u> </u>			
22bc. (County) <u> </u>		22bd. (State) <u> </u>		22be. (City or town) <u> </u>			
22bf. (County) <u> </u>		22bg. (State) <u> </u>		22bh. (City or town) <u> </u>			
22bi. (County) <u> </u>		22bj. (State) <u> </u>		22bk. (City or town) <u> </u>			
22bl. (County) <u> </u>		22bm. (State) <u> </u>		22bn. (City or town) <u> </u>			
22bo. (County) <u> </u>		22bp. (State) <u> </u>		22bq. (City or town) <u> </u>			
22br. (County) <u> </u>		22bs. (State) <u> </u>		22bt. (City or town) <u> </u>			
22bu. (County) <u> </u>		22bv. (State) <u> </u>		22bw. (City or town) <u> </u>			
22bx. (County) <u> </u>		22by. (State) <u> </u>		22bz. (City or town) <u> </u>			
22ca. (County) <u> </u>		22cb. (State) <u> </u>		22cc. (City or town) <u> </u>			
22cd. (County) <u> </u>		22ce. (State) <u> </u>		22cd. (City or town) <u> </u>			
22ce. (County) <u> </u>		22cf. (State) <u> </u>		22ce. (City or town) <u> </u>			
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22ck. (County) <u> </u>		22cl. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cl. (County) <u> </u>		22cm. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cm. (County) <u> </u>		22cn. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cn. (County) <u> </u>		22co. (State) <u> </u>		22cf. (City or town) <u> </u>			
22co. (County) <u> </u>		22cp. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cp. (County) <u> </u>		22cq. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cq. (County) <u> </u>		22cr. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cr. (County) <u> </u>		22cs. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cs. (County) <u> </u>		22ct. (State) <u> </u>		22cf. (City or town) <u> </u>			
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22cu. (County) <u> </u>		22cv. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cv. (County) <u> </u>		22cw. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cw. (County) <u> </u>		22cx. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cx. (County) <u> </u>		22cy. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cy. (County) <u> </u>		22cz. (State) <u> </u>		22cf. (City or town) <u> </u>			
22cz. (County) <u> </u>		22da. (State) <u> </u>		22cf. (City or town) <u> </u>			
22da. (County) <u> </u>		22db. (State) <u> </u>		22cf. (City or town) <u> </u>			
22db. (County) <u> </u>		22dc. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dc. (County) <u> </u>		22dd. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dd. (County) <u> </u>		22de. (State) <u> </u>		22cf. (City or town) <u> </u>			
22de. (County) <u> </u>		22df. (State) <u> </u>		22cf. (City or town) <u> </u>			
22df. (County) <u> </u>		22dg. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dg. (County) <u> </u>		22dh. (State) <u> </u>		22cf. (City or town) <u> </u>			
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22dk. (County) <u> </u>		22dl. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dl. (County) <u> </u>		22dm. (State) <u> </u>		22cf. (City or town) <u> </u>			
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22dq. (County) <u> </u>		22dr. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dr. (County) <u> </u>		22ds. (State) <u> </u>		22cf. (City or town) <u> </u>			
22ds. (County) <u> </u>		22dt. (State) <u> </u>		22cf. (City or town) <u> </u>			
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22dv. (County) <u> </u>		22dw. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dw. (County) <u> </u>		22dx. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dx. (County) <u> </u>		22dy. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dy. (County) <u> </u>		22dz. (State) <u> </u>		22cf. (City or town) <u> </u>			
22dz. (County) <u> </u>		22ea. (State) <u> </u>		22cf. (City or town) <u> </u>			
22ea. (County) <u> </u>		22eb. (State) <u> </u>		22cf. (City or town) <u> </u>			
22eb. (County) <u> </u>		22ec. (State) <u> </u>		22cf. (City or town) <u> </u>			
22ec. (County) <u> </u>		22ed. (State) <u> </u>		22cf. (City or town) <u> </u>			
22ed. (County) <u> </u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8910

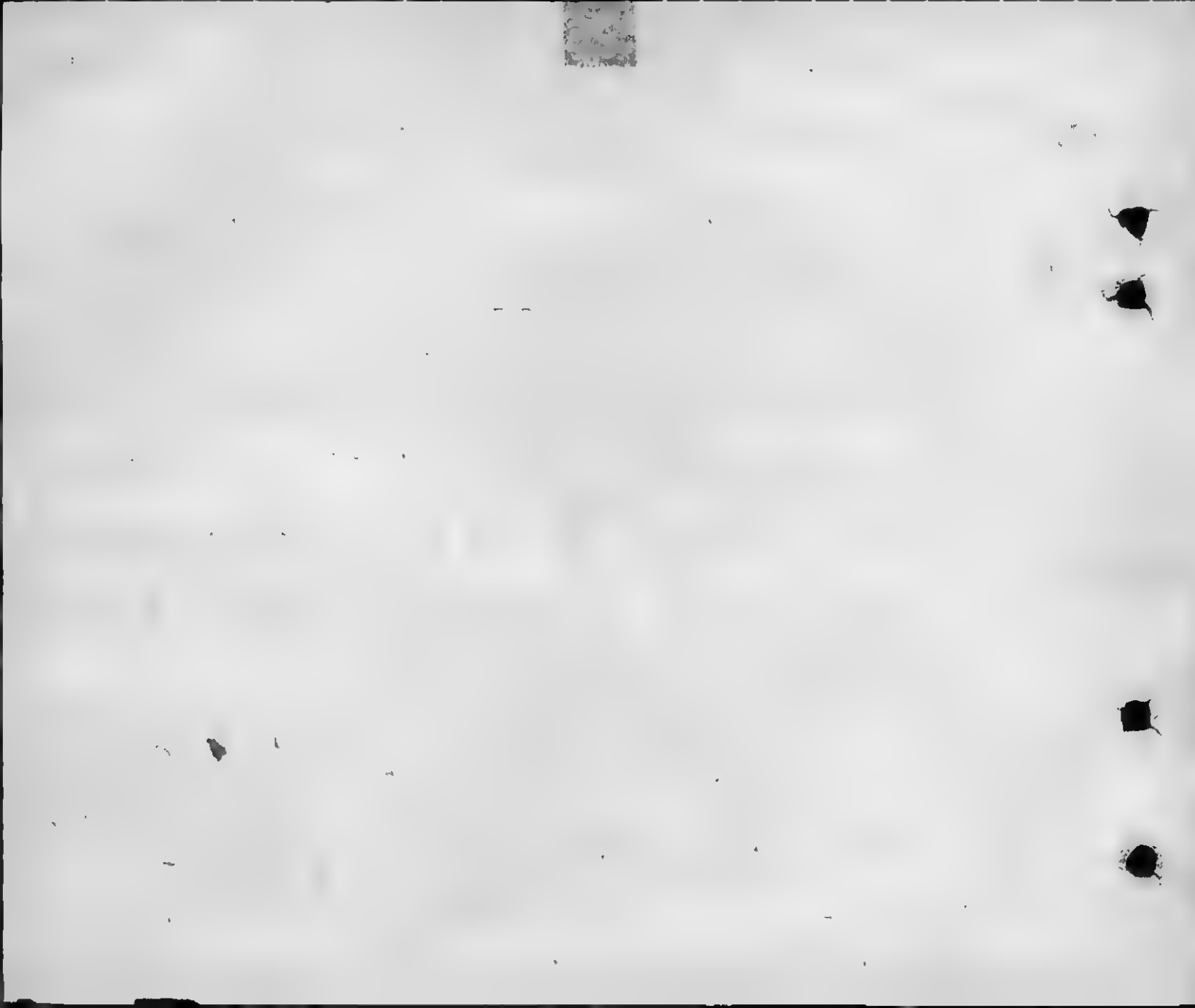
CERTIFICATE OF DEATH

08902

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1313 Westellen Rd.</u>		d. STREET ADDRESS <u>1313 Westellen Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Rinehart</u>		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>19 61</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-8-1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>24</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Brewer</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Gildenfenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs Helen M. Christ</u>		17. INFORMANT <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u>		June 1958	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from... <u>June 1958</u> to <u>Aug 24, 1961</u> , that (I) (we) last saw the deceased alive on... <u>Aug 22, 1961</u> , and that death occurred at <u>7A M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Harold H. Burns</u>		22b. DATE SIGNED <u>8/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>		22d. ADDRESS <u>8106 Harford Rd. #</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		23e. REC'D BY REGISTRAR <u>DATE AUG 28 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Christina S. Hines</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24b. ADDRESS <u>5305 Harford Rd.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO ASSISTANT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician must be filled in by the funeral director. The funeral director must sign this certificate. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8911

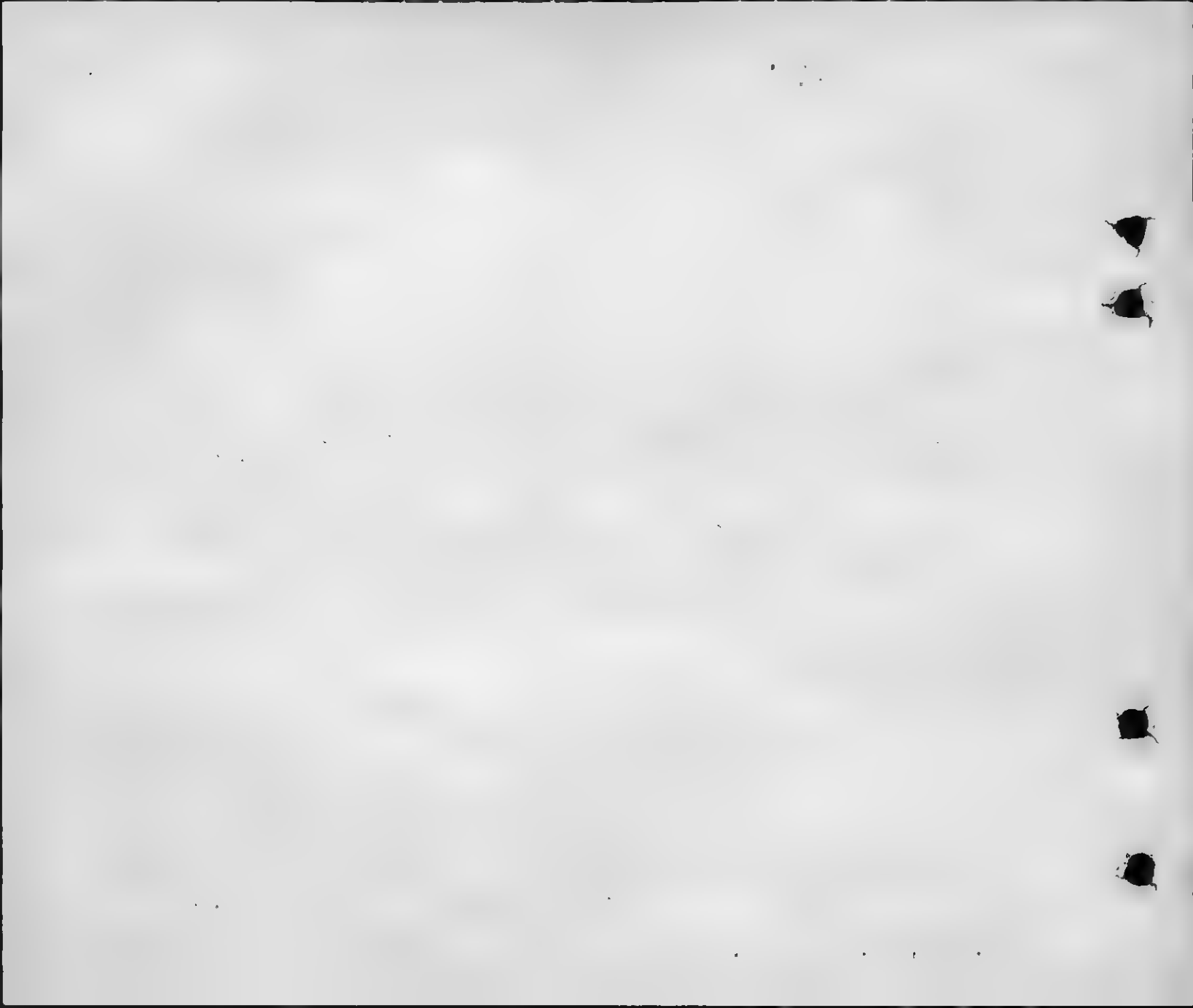
08903

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE c. LENGTH OF STAY in 1b 15 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MASONIC HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY BALTIMORE g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE h. STREET ADDRESS 5218 BIDDISON LANE i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAIRE PRICE ROBINSON First Middle Last 4. DATE OF DEATH AUG 8 1961 Month Day Year		5. SEX FE 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1-1-1875 9. AGE (in years last birthday) 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (County & State, or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JAMES H. PRICE 14. MOTHER'S MAIDEN NAME MARY ZIMMERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease DUE TO (b) 15 months Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12-1961 to 8-7-1961 , that (I) (we) last saw the deceased alive on 8-7-1961 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.		22a. SIGNATURE Walter T. Kees 22b. DATE SIGNED 8-8-61 22c. PHYSICIAN'S NAME (Type) WALTER T. KEES 22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 8-10-61 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Md		24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street ADDRESS 25a. REC'D BY REGISTRAR AUG 9 '61 25b. REGISTRAR'S SIGNATURE Charles L. Hines	

M

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MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8912

08904

1. PLACE OF DEATH a. COUNTY: <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Middle River</u> c. LENGTH OF STAY IN 1b: _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): _____				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Middle River</u> d. STREET ADDRESS: <u>#2 Locust Drive #20</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Anna Sacks</u>		4. DATE OF DEATH Month Day Year <u>August 25 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1874</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY : _____				11. BIRTHPLACE (County & State or foreign country): <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME : <u>Rush</u> 14. MOTHER'S MAIDEN NAME : <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT Name: <u>Mr. William H. Sacks</u> Address: <u>#2 Locust Grove Rd.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory failure</u> (b) <u>Cerebral vascular accident</u> (c) <u>arteriosclerotic cardio-vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>Heart failure, chronic</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				20c. TIME OF INJURY Month, Day, Year: _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): _____ 20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>July 29, 1961</u> to <u>August 23, 1961</u> that (I) (we) last saw the deceased alive on <u>August 23, 1961</u> and that death occurred at <u>7 AM</u> from the causes and on the date stated above.													
22. SIGNATURE <u>Eugene C. Baumann</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>EUGENE C. BAUMANN</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>413 EASTERN AVE, BALTIMORE 21, Md.</u>				22b. DATE SIGNED <u>8-26-61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/28/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> 23d. LOCATION (City, town or county) <u>Woodlawn, Maryland</u> (State) _____									
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tickenor</u>				25a. REC'D BY REGISTRAR <u>Aug 29 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles S. Young</u>									

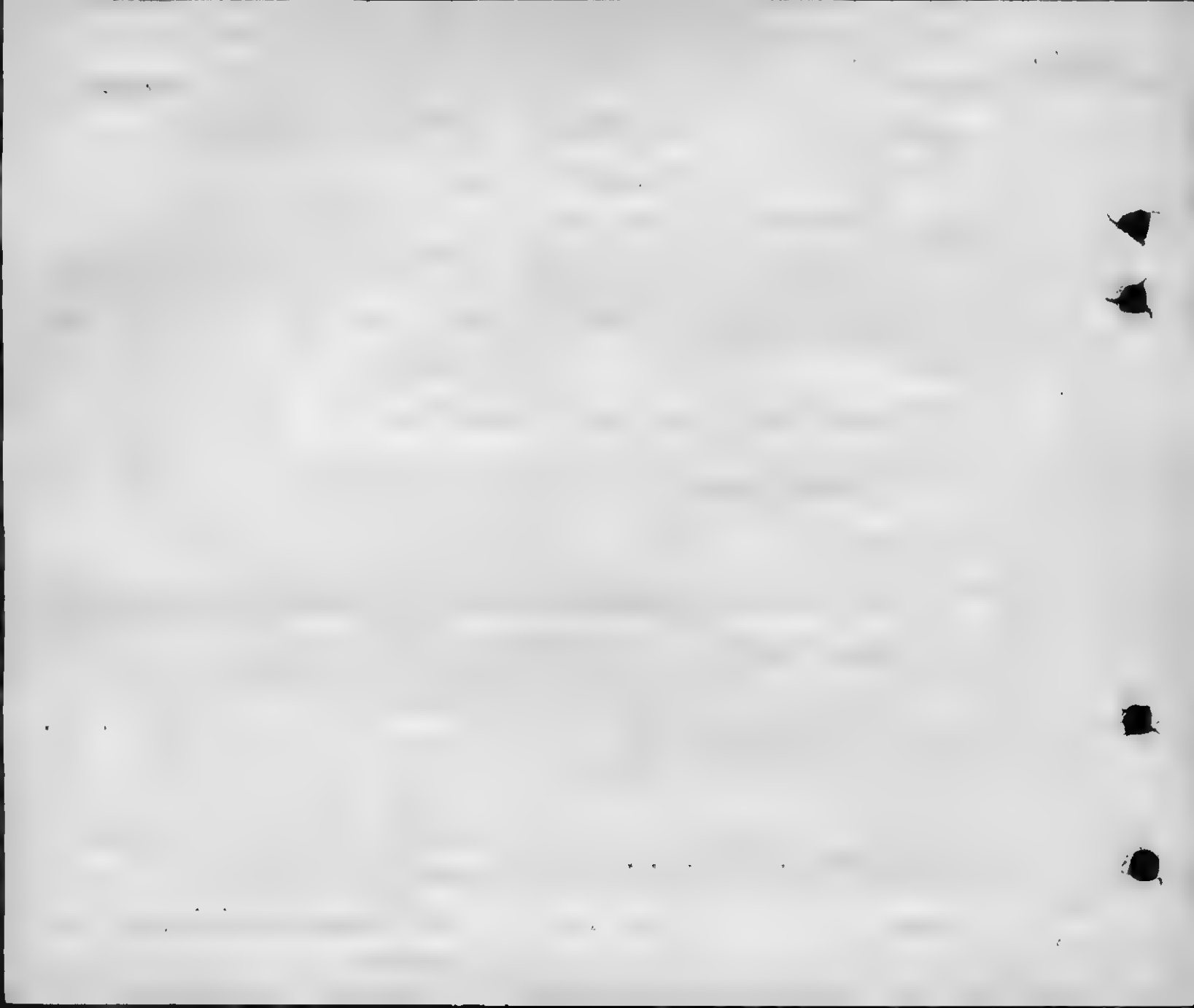
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it must be filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE Puerto Rico b. COUNTY Ciales c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 30, Reisterstown		d. STREET ADDRESS Box 546 Ciales	
3. NAME OF DECEASED (Type or print) First PABLO Middle ANTONIO Last SANTIAGO-ANDUGAR		4. DATE OF DEATH Month August Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE Puerto Rican	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of base of skull DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which overturned and deceased was thrown from car	
20c. TIME OF INJURY Hour 10:15 p.m. Month, Day, Year 8/20/ 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 30	20f. (City or town) (County) (State) Reisterstown, Baltimore, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		DATE SIGNED 8/21/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9.6.61	22c. NAME OF CEMETERY OR CREMATORY of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR from City Morgue		24a. REC'D BY REGISTRAR 8 '61 24b. REGISTRAR'S SIGNATURE Julius S. Kline	

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, to the Medical Director. Page 1, 2, 3, 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



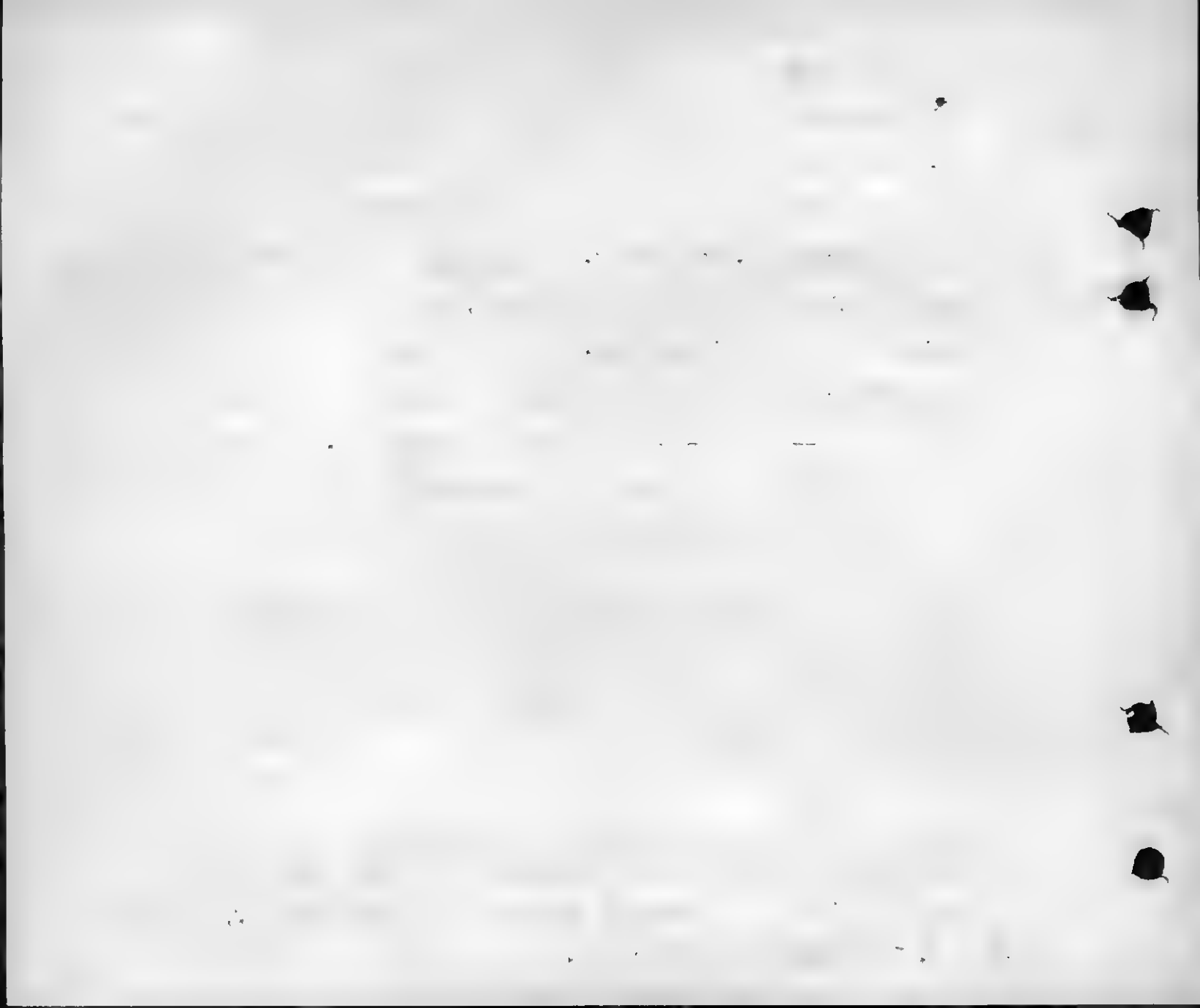
08905

2914

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, adding the word "pending" in pencil in item 18. Give Pages 1, 2, 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08906									
1. PLACE OF DEATH a. COUNTY <u>Balto.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carroll</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>				
c. LENGTH OF STAY IN 1b <u>4 days</u>					d. STREET ADDRESS <u>6644 Balton Lane</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <u>Foreign Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>FANNIE</u>					4. DATE OF DEATH <u>Aug 31 1961</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>July 30, 1901</u>				
9. AGE (In years, if UNDER 1 YEAR, last birthday) Months Days Hours Min. <u>60</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Lithuania</u>				
11. BIRTHPLACE (State or country) <u>USA</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Late Benjamin Koppel</u>					14. MOTHER'S MAIDEN NAME <u>Late Hinda ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>215-34-1050</u>				
17. INFORMANT <u>Howard K. Schaff, 4747 Belle Ford Rd.</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>157X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Baltimore</u> 20g. (City or town) (County) (State) <u>Baltimore</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>D.D. Caples</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>9/1/61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfeloh Cong.</u>					22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>				
23. FUNERAL DIRECTOR <u>Sol Levinson & Bros., 6010 Reist. Rd., Balto 15</u>					24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>				
ADDRESS <u>Sol Levinson & Bros., 6010 Reist. Rd., Balto 15</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

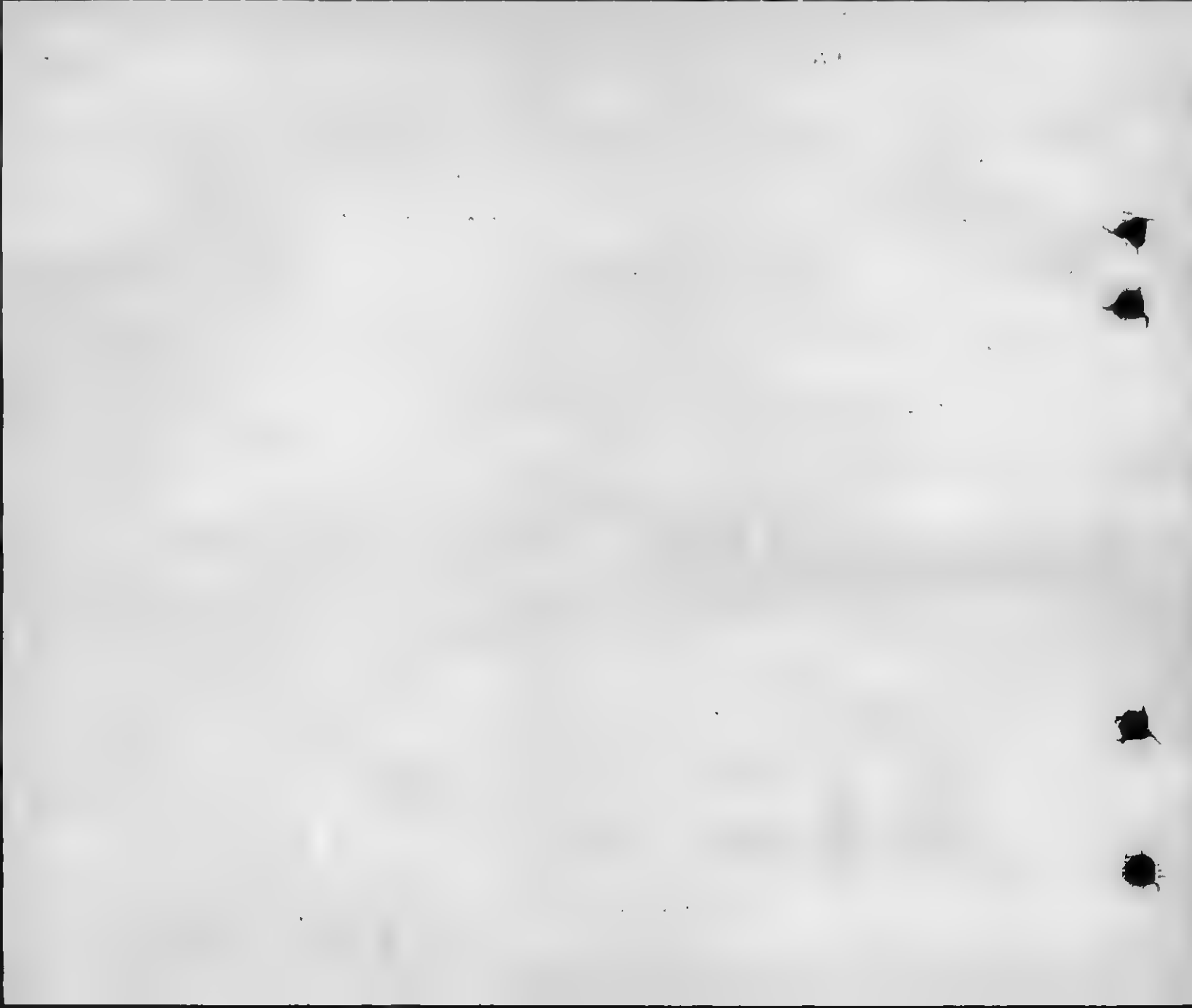
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8915

118908

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>146 Oak Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> d. STREET ADDRESS <u>146 Oak Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>LOU V. Scott</u>		4. DATE OF DEATH <u>8 - 12 - 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-20-1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Prince Edward Co., Va. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Perrin</u>		14. MOTHER'S MAIDEN NAME <u>Ella Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Lea V. Jeffers</u> Address <u>1218 N. Spring St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Insufficiency</u> DUE TO (b) <u>Arterio-sclerotic HEART DISEASE</u> DUE TO (c) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> <u>1955</u> to <u>8/12</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>June</u> <u>1961</u> and that death occurred at <u>8:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. J. M. Jones Jr MD</u>		22b. DATE SIGNED <u>8/15/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1640 CAROLINE ST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8-15-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Farmville, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Pollock</u>		25a. REC'D BY REGISTRAR <u>AUG 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Havel</u>		25c. ADDRESS <u>1412 E. Preston St.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8917

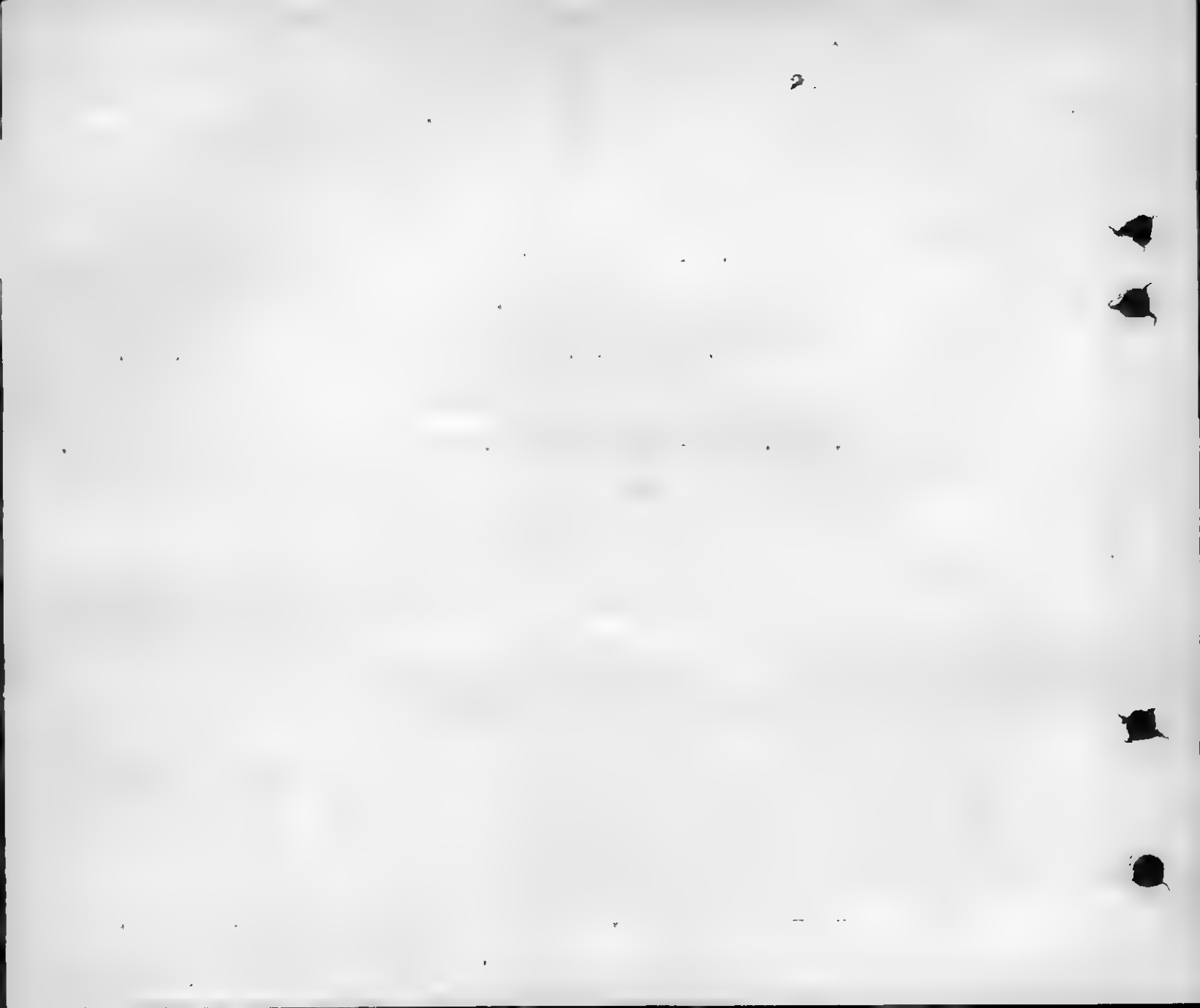
CERTIFICATE OF DEATH

Reg. Dist. No. 08942

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admittance) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 4614 Reisterstown Road	
3. NAME OF DECEASED (Type or print) First Arthur W. H. Middle Schultz Last Schultz		4. DATE OF DEATH Month August Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1874
9. AGE (In years last birthday) yrs 87		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Builder		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	
16. SOCIAL SECURITY NO. 219-01-0663		17. INFORMANT Mrs. M.V. Bright Address 4614 Reisterstown Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 467.2 Arteriosclerotic Changes of heart by DUE TO Vascular Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 18, 1961 , to Aug 22, 1961 , that I last saw the deceased alive on Aug 22, 1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.		ADDRESS (Street, city or town, state) 4605 Edmonds Ave DATE SIGNED 8/23/61	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.		LOCATION (City, town, or county) (State) Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-25-1961	22c. NAME OF CEMETERY OR CREMATORY Balto. National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon ADDRESS 4611 Park Heights Ave.,		24a. REC'D BY REGISTRAR DATE AUG 25 '61	24b. REGISTRAR'S SIGNATURE Arthur L. House

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. After the attending physician has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4 of 4
Page 1 of 1
Page 2 of 2
Page 3 of 3
Page 4 of 4

VR A15 (4)
TSM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

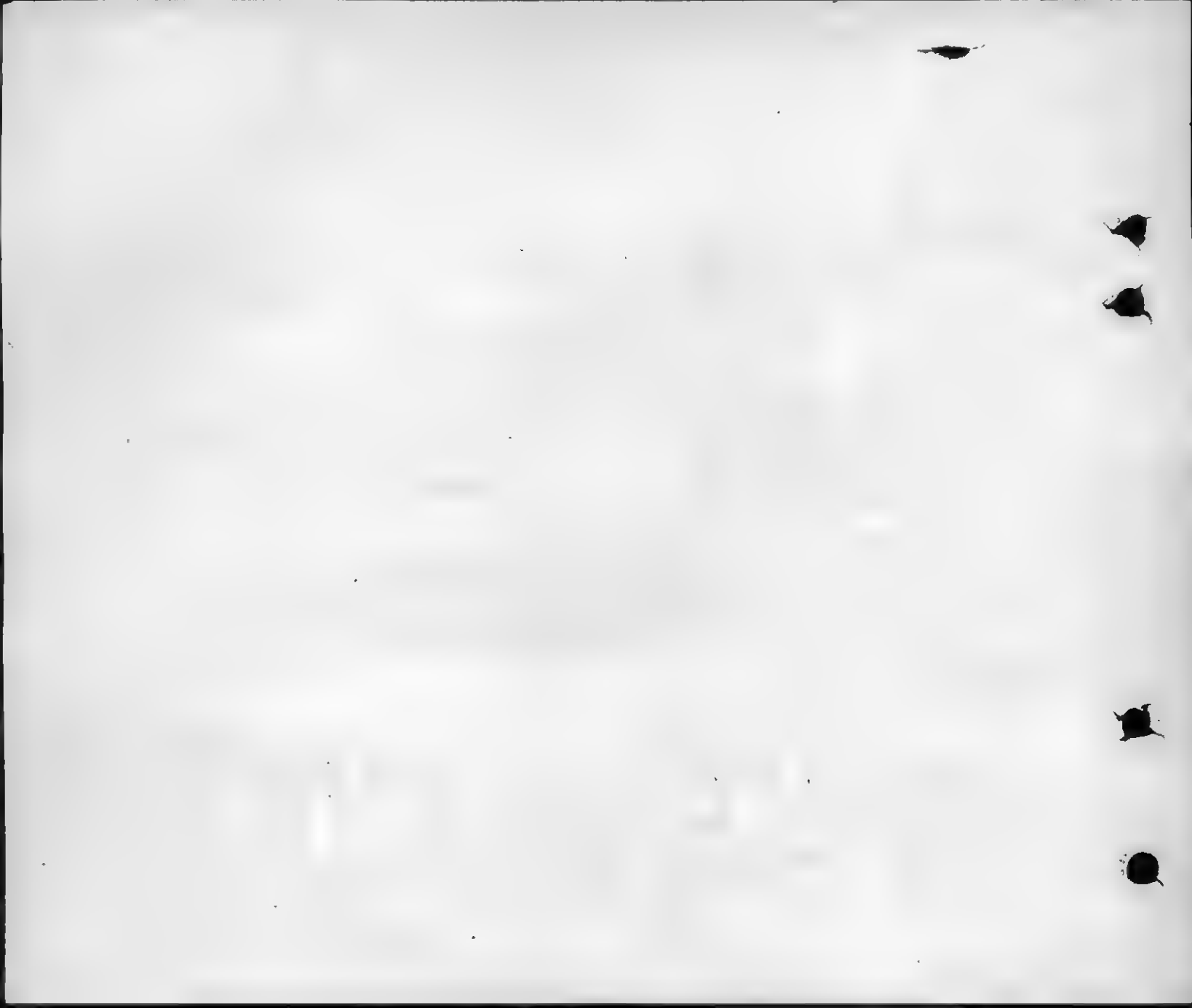
may be obtained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8918

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08909

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore (Arbutus)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5552 Carville Avenue		d. STREET ADDRESS 5552 Carville Avenue					
3. NAME OF DECEASED (Type or print) Helena		First D.		Middle SXX Sewell		Last August 9, 1961	
4. DATE OF DEATH August 9, 1961		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 4, 1872		9. AGE (In years last birthday) 89 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nursing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Heiner		14. MOTHER'S MAIDEN NAME Fredericka Fredericka Marrs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Marguerite Huber 5552 Carville Avenue #27		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of liver - (c) Perforation of duodenum - Subcutaneous hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 wks 1 month + 10 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ✓		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10:30 a.m. to 10:30 p.m. on Aug 9, 1961, that (I) (we) last saw the deceased alive on Aug 9, 1961, and that death occurred on Aug 9, 1961, from the causes and on the date stated above.		22a. SIGNATURE Frederic V. Beitler	
22b. DATE SIGNED Aug 14 '61		22c. PHYSICIAN'S NAME (Type) Frederic Beitler, M. D.		22d. ADDRESS Francis Avenue, Halethorpe 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/12/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue Md.		ADDRESS Baltimore		25a. REC'D BY REGISTRAR AUG 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	



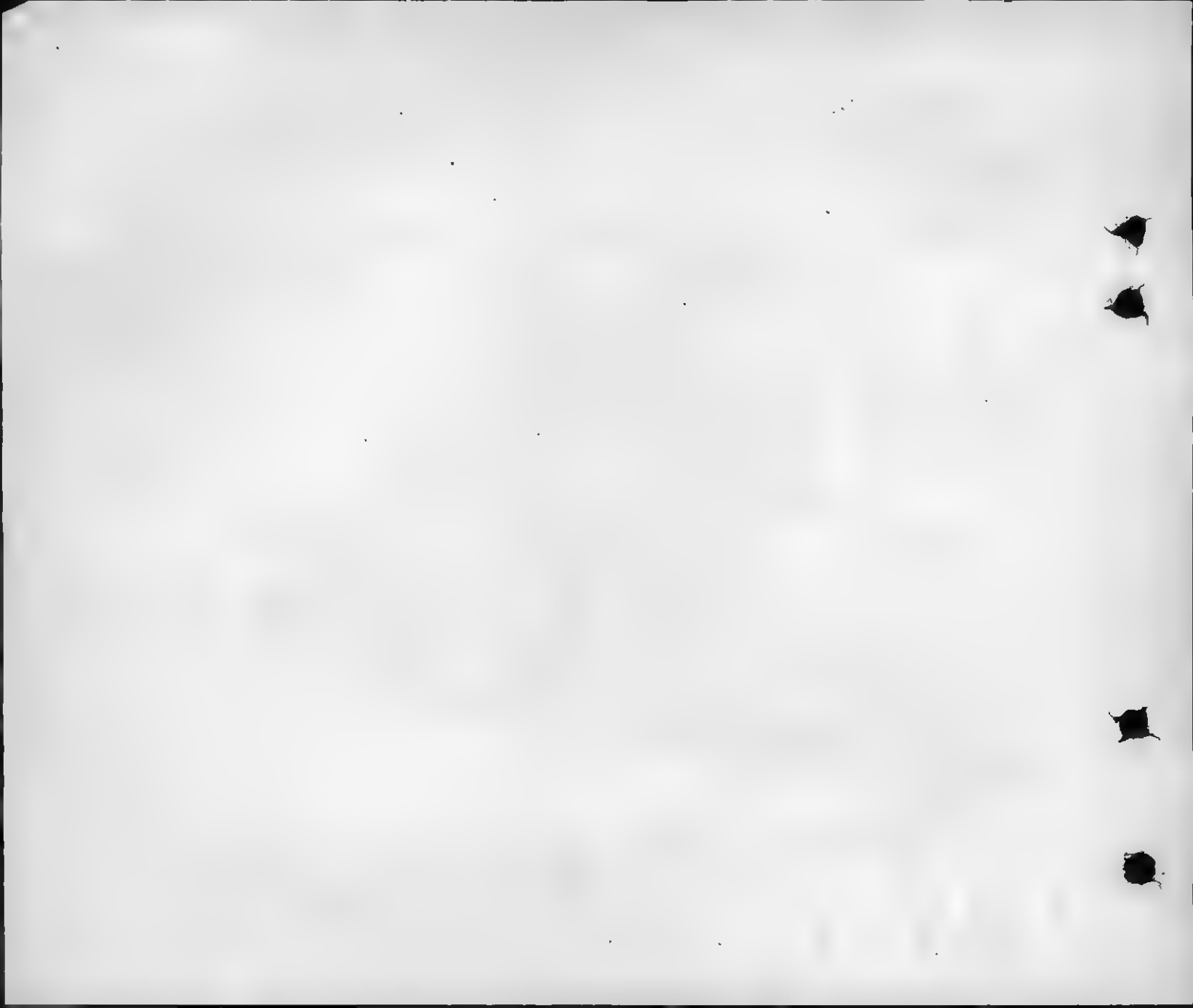
may be signed by the attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8919

08910

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u> c. LENGTH OF STAY IN lb <u>11020 Mace Ave.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1020 Mace Ave.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u> d. STREET ADDRESS <u>11020 Mace Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN EDWARD SHANAHAN</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-15-1908</u> 9. AGE (In years last birthday) <u>52</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>Aug. 7TH 1961</u> Month Day Year 13. FATHER'S NAME <u>John Shanahan</u> 14. MOTHER'S MAIDEN NAME <u>Miller</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>214-01-5088</u> 16. SOCIAL SECURITY NO <u>214-01-5088</u> 17. INFORMANT <u>Joe. F. Shanahan (same as above)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> DUE TO <u>Cancer of the lung with extensive metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> to <u>8/7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> 19 <u>61</u> , and that death occurred at <u>2</u> PM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Eugene C. Baumann</u> 22c. PHYSICIAN'S NAME (Type) <u>EUGENE C. BAUMANN</u>		22b. ADDRESS <u>413 EASTERN AVE, BALTIMORE 21, Md.</u> 22d. ADDRESS <u>413 EASTERN AVE, BALTIMORE 21, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-11-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cem.</u> 23d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u> ADDRESS <u>418 Eastern Blvd. 21 Md.</u> 25a. REC'D BY REGISTRAR DATE <u>AUG 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	



8920

CERTIFICATE OF DEATH

Reg. Dist. No.

08917

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 BROADSHIP RD		d. STREET ADDRESS 62 BROADSHIP	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE LEO SHEARER		4. DATE OF DEATH Month Day Year AUG. 21 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY HOME CONSTR.	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM. SHEARER		14. MOTHER'S MAIDEN NAME MARY A. KRAUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 226-16-9383	
17. INFORMANT MRS. WM. J. LONG		Address AS #2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YRS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 1955 to 21 AUG. 1961 , that I last saw the deceased alive on 27 MARCH 1961 , and that death occurred at 2:10 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 1105 OLD EASTERN AVE.		DATE SIGNED 8-21-61	
ACTUAL SIGNATURE Morris Rainess		M.D. ESSEX 21, MD.	
PHYSICIAN'S NAME (Type) MORRIS RAINESS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE/THEREOF 8/24/61	22c. NAME OF CEMETERY OR CREMATORY ST. BONIFACE CHURCHYARD LEADING CREEK - W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Bradley		24a. M.D. BY REGISTRAR DATE	
ADDRESS 700 Shelton Spring		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2921

08912

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6805 ROBERTS AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> d. STREET ADDRESS <u>6805 Roberts Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>ANDREW W. SMINK</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/10/1942 (12)</u> 9. AGE (In years last birthday) <u>48</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL</u> 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4. DATE OF DEATH <u>8 13 1961</u> Month Day Year F UNDER 1 YEAR Months Days F UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>SMINK</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>204-094868</u> 17. INFORMANT <u>ELEANOR</u> Address <u>6805 Roberts Ave.</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>720.1 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY OCCLUSION</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <u>8-17-61</u>		Address (Street, city, town, or county) <u>BALTIMORE MARYLAND</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Stalter</u>		24a. REC'D BY REGISTRAR <u>DEC 16 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE <u>8/14/61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filled in by the funeral director, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8922 CERTIFICATE OF DEATH 08913											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shepperd Road						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton d. STREET ADDRESS Shepperd Road e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joe Morrison Sparks						4. DATE OF DEATH Aug. 2 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1877		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming						10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (County & State, or foreign country) USA			
13. FATHER'S NAME Francis Morrison Sparks						14. MOTHER'S MAIDEN NAME Julia Remare					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no						16. SOCIAL SECURITY NO. 213-38-6504					
17. INFORMANT Pauline P. Sparks						Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) Arterio-sclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1959 to Aug. 2 , 19 61 that (I) (we) last saw the deceased alive on Aug. 1 , 19 61 , and that death occurred at 5a.m. from the causes and on the date stated above.											
22a. SIGNATURE A.M. France M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) A.M. France 22d. ADDRESS Parkton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8-4-61 23c. NAME OF CEMETERY OR CREMATORY St. Johns (Long Green) 23d. LOCATION (City, town or county) (State) Baltimore County Md											
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd., 12 25a. REC'D BY REGISTRAR AUG 4 '61 25b. REGISTRAR'S SIGNATURE Carlton E. France											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8923											
08914											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> c. LENGTH OF STAY IN b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sheppard Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> d. STREET ADDRESS <u>Sheppard Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First Middle Last 4. DATE OF DEATH <u>Aug. 8 1961</u> Month Day Year						5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-29-1871</u> 9. AGE (in years) <u>90</u> yrs. <u>90</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Brooke Pleasants</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Jenkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>--</u> 17. INFORMANT <u>Helen Troy Hayden</u> Address <u>Washington, D.C.</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> 199x DUE TO (b) <u>199x</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>199x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e); 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1961</u> to <u>Aug 8, 1961</u> that (I) (we) last saw the deceased alive on <u>Aug 8, 1961</u> and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>A.M. France</u> M.D. 22b. DATE SIGNED <u>8/9/61</u> 22c. PHYSICIAN'S NAME (Type) <u>A.M. FRANCE</u> 22d. ADDRESS <u>PARTXON, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-11-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u> ADDRESS <u>Balto Co. (Hyde P.O.) Md.</u>						23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons CO.</u> 25a. REC'D BY REGISTRAR <u>DATE AUG 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>W. S. H. H. H.</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2924

08915

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

FORT HOWARD

21 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

VETERANS ADMINISTRATION HOSPITAL

3. NAME OF DECEASED
(Type or print)

SAMUEL

STAFFORD

5. SEX

Male

6. COLOR OR RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

MARCH 17, 1895

9. AGE (In years last birthday)

66 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Oyster Shucker

10b. KIND OF BUSINESS OR INDUSTRY

Oyster Company

11. BIRTHPLACE (County & State, or foreign country)

Cambridge, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Martin L. Stafford

14. MOTHER'S MAIDEN NAME

Lucy Stiles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

YES

WW I

16. SOCIAL SECURITY NO.

217-10-8667

17. INFORMANT

Clin. Records, VAH, Balto. Md. Ft. Howard Division

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).

CARCINOMA OF LUNG WITH METASTASIS TO BRAIN

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from August 5, 1961 to August 26, 1961, that (we) last saw the deceased alive on August 26, 1961 and that death occurred at 3:15 AM from the causes and on the date stated above.

22a. SIGNATURE

M. Lawrence Rubin, M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

8/27/61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

M. LAWRENCE RUBIN, M.D.

VAH, BALTO. MD. FT. HOWARD DIV.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

8-31-61

23c. NAME OF CEMETERY OR CREMATORY

Bethel Cemetery

23d. LOCATION (City, town or county)

Cambridge, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Elroy O. Wilson Funeral Home, 1000 Brantley Ave. Baltimore, Md.

25a. REC'D BY REGISTRAR

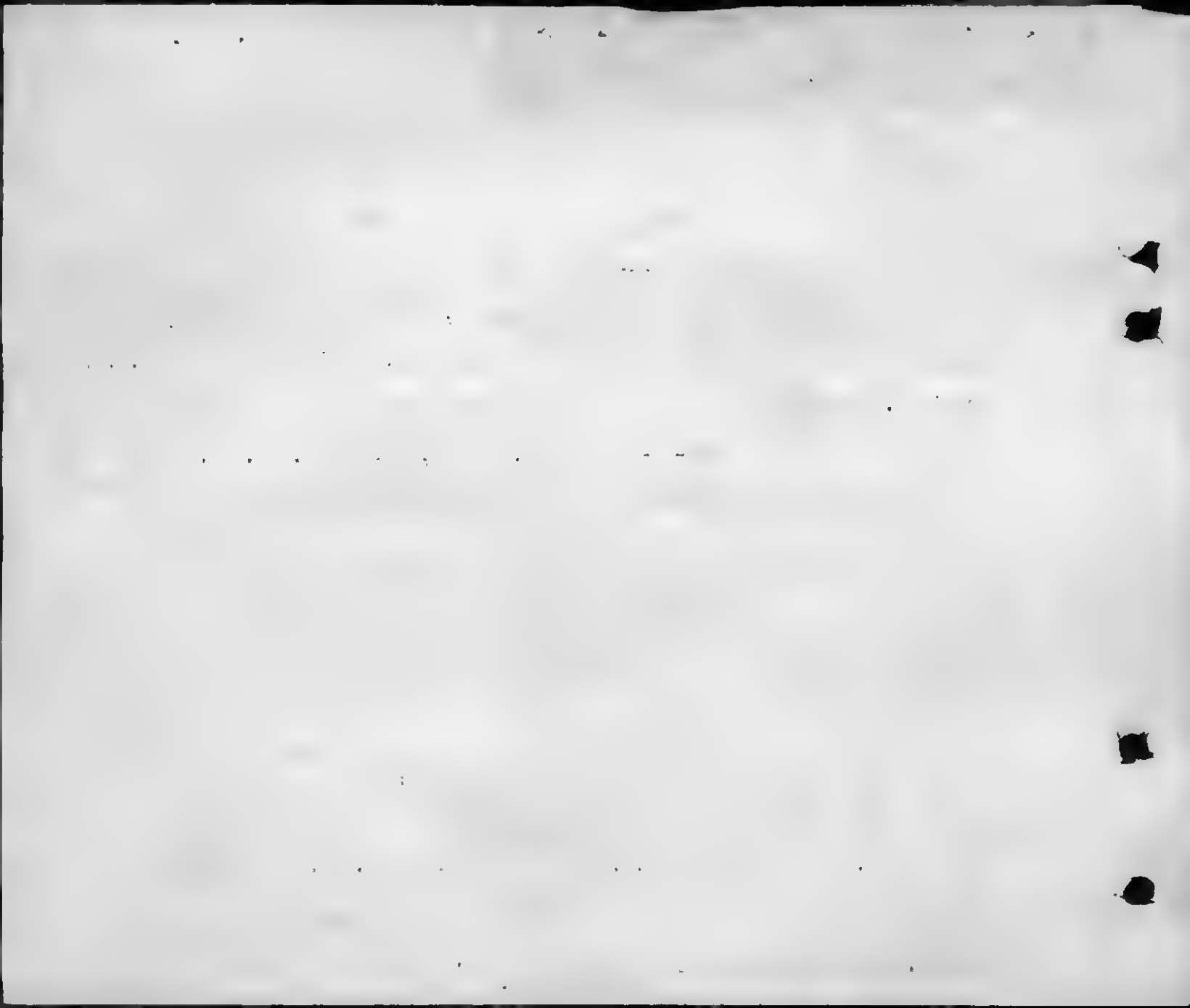
AUG 30 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8925

08916

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) ESSEX c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GRAND-BAUGH TER'S HOME				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY ✓ c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) BALTO. d. STREET ADDRESS 334 S. ROBINSON ST.			
3. NAME OF DECEASED (Type or print) ANNA MAY STICHEL 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				4. DATE OF DEATH AUG. 2 1961 8. DATE OF BIRTH AUG. 26, 1890 9. AGE (in years last birthday) 70 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TICKET MGR. THEATER 11. BIRTHPLACE (County & State, or foreign country) MD. USA 12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME THOMAS SIMS 14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 214-22-3838 17. INFORMANT CHARLES STICHEL Address 334 S. ROBINSON				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHO SARCOMA OF RT. INGUINAL (b) WITH METASTASIS TO SPLEEN LUNG (c) AND BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 20 0 0 1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) EXCISION OF MASS AT S.B.G. 7-21-61			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. NONE p.m. 19 20d. INJURY OCCURRED When at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) NONE 20f. (City or town) NONE (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from 4-10-61 to 8-2-61, that (I) (we) last saw the deceased alive on 8-2-61, and that death occurred at 3 PM, from the causes and on the date stated above. 22a. SIGNATURE E. A. Schimmuck M.D. 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) E. A. SCHIMMUCK MD. Address 842 S. EAST AVE BALTO, 24 MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF AUG. 5, 61 23c. NAME OF CEMETERY OR CREMATORY oak lawn 23d. LOCATION (City, town or county) BALTO. CO. MD. (State) _____				24. FUNERAL DIRECTOR'S SIGNATURE B. V. Hoffmann Address 3218 HUDSON ST. 25a. REC'D BY REGISTRAR AUG 4 '61 DATE 25b. REGISTRAR'S SIGNATURE C. L. S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



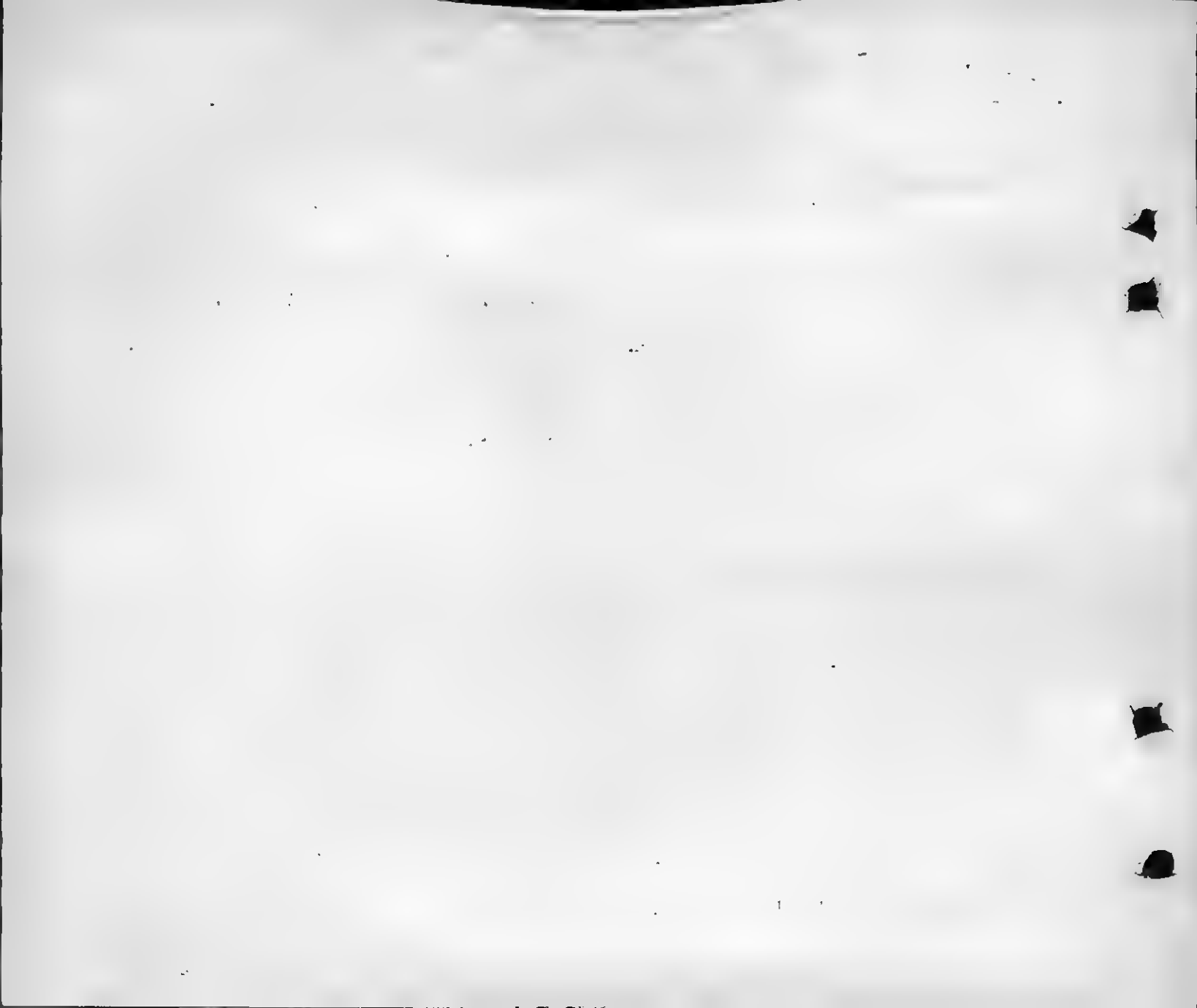
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08917

8926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5232 Arbutus Avenue				d. STREET ADDRESS 5232 Arbutus Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Stier, Sr.				4. DATE OF DEATH Month August Day 21 , Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1875	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O R. R.		10b. KIND OF BUSINESS OR INDUSTRY Foreman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Stier				14. MOTHER'S MAIDEN NAME Mary F. Jamart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Bertha W. Stier 5232 Arbutus Avenue #XX #27			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO (c) myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to May 1, 1961 , that (I) (we) last saw the deceased alive on May 1, 1961 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Stanley Ankudas, M. D.				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 1802 W. Baltimore Street			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/61		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) Howard County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue #29				25a. REC'D BY REGISTRAR DATE 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and competently filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 5 days
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1624 Light Street

3. NAME OF DECEASED (Type or print) Howard John Stokes
4. DATE OF DEATH August 24 1961
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH April 7, 1903
8. AGE (in years last birthday) 58 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance 10b. KIND OF BUSINESS OR INDUSTRY restaurant 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Thomas Stokes 14. MOTHER'S MAIDEN NAME Bertha Lettau

15. WAS DECEASED EVER IN U.S. ARMED FORCES? ☐ 16. SOCIAL SECURITY NO. Natl. Guard 110th fld. art. -Pikesvll. 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia - entire right lung
49.3 X Heart failure
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. atrial fibrillation & myocardial damage long standing
DUE TO (c) cellulitis - left leg
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Aug. 24 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that Stella Wachslor (this hospital) attended the deceased from Aug. 19 1961 to Aug. 24 1961, that (I) (we) last saw the deceased alive on Aug. 24 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE Stella Wachslor M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 8-25-61 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Aug. 31, 1961 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Flynn & Fleming, 1422 Light St. Balto. Mu. ADDRESS 25a. REC'D BY REGISTRAR Aug 29 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

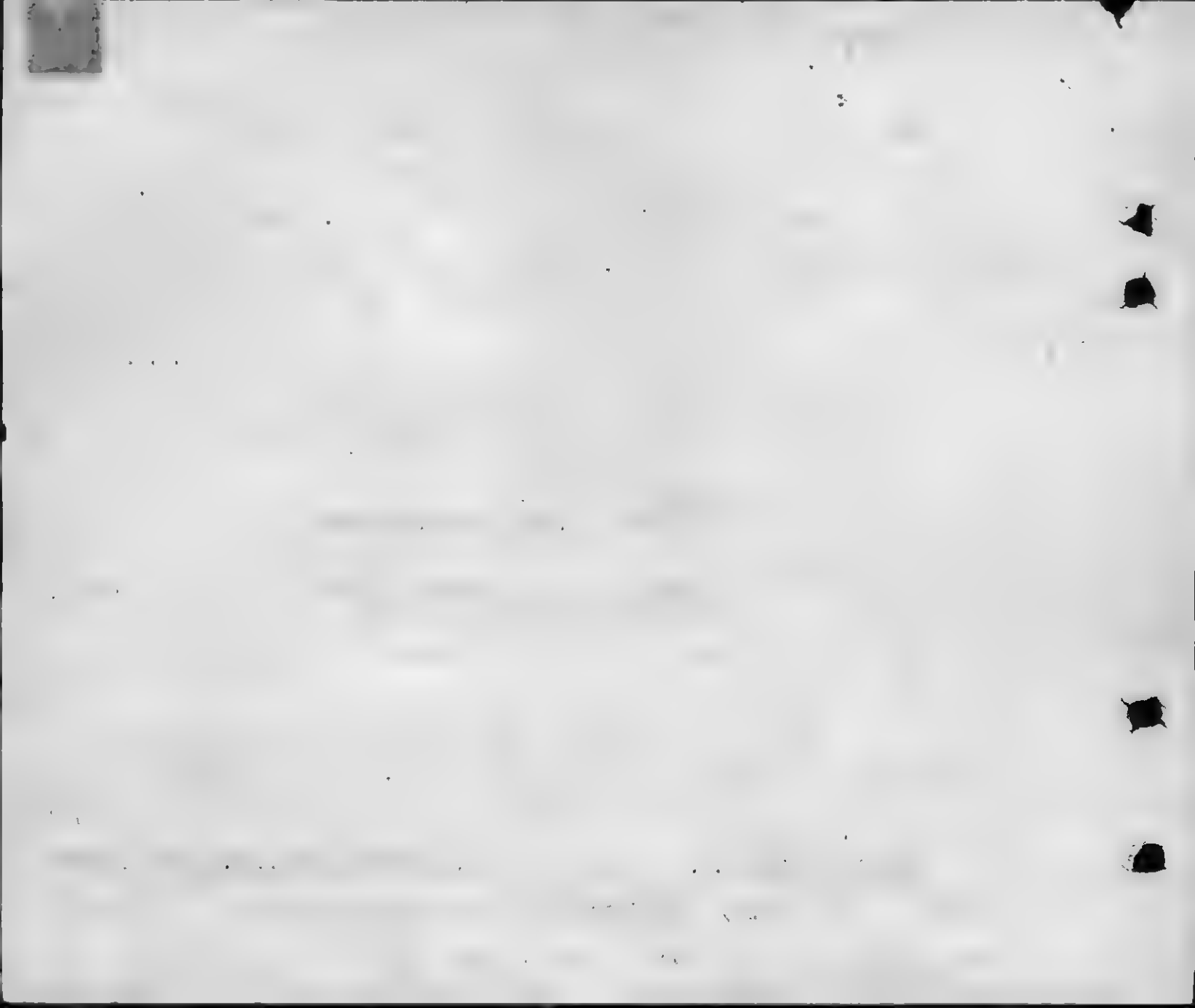
3527

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08919

Item 2 Film G-95-9/21/61 inv

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN IL <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Sts.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Mayfair Hotel, Mt. Royal & Charles</u>	
3. NAME OF DECEASED (Type or print) <u>HERBERT E. SWEETLAND</u>		4. DATE OF DEATH <u>August 29 19 61</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>December 20, 1906</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Clubs</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Sweetland</u>		14. MOTHER'S MAIDEN NAME <u>Cora Hermert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>547-07-9837</u>	
17. INFORMANT <u>Clinical Records, VAH, 3900 Loch Raven Blvd. Baltimore 18, Md - FORT HOWARD DIVISION</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>THROMBOSIS OF RIGHT CORONARY ARTERY</u> Conditions, if any, which gave rise to immediate cause (b) <u>ULCERATION OF OROPHARYNGEAL REGION</u> (c) <u>ULCERATION OF OROPHARYNGEAL REGION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY: Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>August 23, 1961</u> , to <u>August 29, 1961</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>August 29, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE <u>8/31/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8928

08920

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre deGrace, Maryland	
c. LENGTH OF STAY IN TB 9yr4mth2dys		d. STREET ADDRESS 716 Ontario Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Thompson		4. DATE OF DEATH Month Aug Day 11 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 11 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph McVey		14. MOTHER'S MAIDEN NAME Josephine Tollinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 577-40-7501	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. DUE TO (c) CARDIOVASCULAR COLLAPSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from April 9, 1952 to 8-11-61 , 19 61 , that (I) (we) last saw the deceased alive on 8-11-1961 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Arizaga		22b. DATE SIGNED 8/11/61	
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG 15 1961	23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM CEM.	
23d. LOCATION (City, town or county) (State) CECIL, CO MD		23e. REC'D BY REGISTRAR AUG 16 '61	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

7-11-11 11:11 11:11
11-11-11 11:11 11:11
11-11-11 11:11 11:11
11-11-11 11:11 11:11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

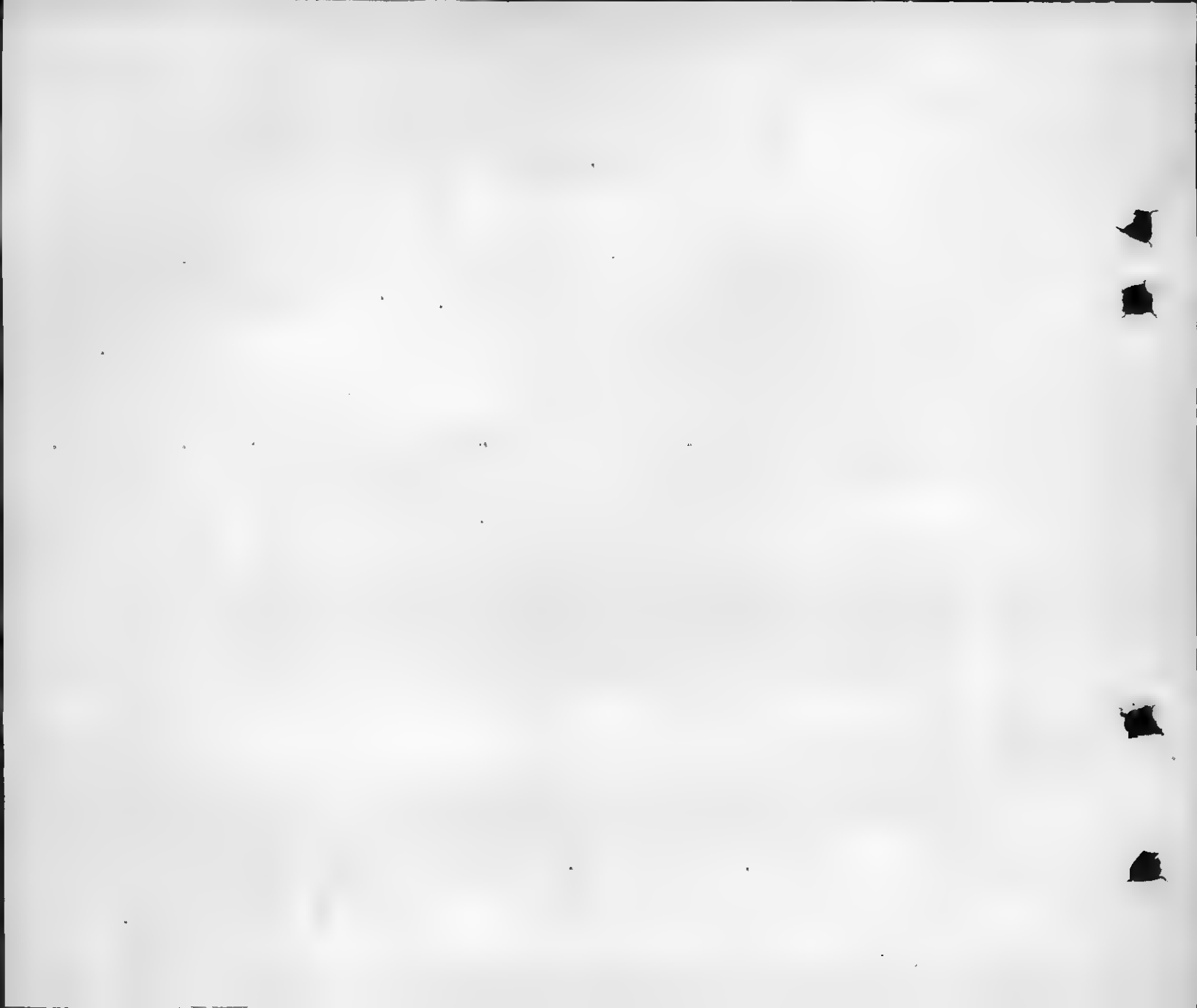
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8929

08921

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 661 Oella Avenue		d. STREET ADDRESS 1 661 Oella Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle G. Last Tipton		4. DATE OF DEATH Month Aug. Day 2, Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1884
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Canapp		14. MOTHER'S MAIDEN NAME Mary Josephine Garrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-6077	
17. INFORMANT Address Mrs. Edwin Fisher 661 Oella Ave. Oella, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO Hypertensive Cardio-Vasc Disease (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 4, 1956 to Aug 2, 1961 , that (I) (we) last saw the deceased alive on Aug 1, 1961 , and that death occurred at 6 P. M. from the causes and on the date stated above.			
22a. SIGNATURE William F. Cassaway M. D.		22b. DATE SIGNED Aug 2, 1961	
22c. PHYSICIAN'S NAME (Type) William F. Cassaway M. D.		22d. ADDRESS Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/1961	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR Aug 7 '61	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



Arthur L. Krens

Y5. A15ME
SM 9/60



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

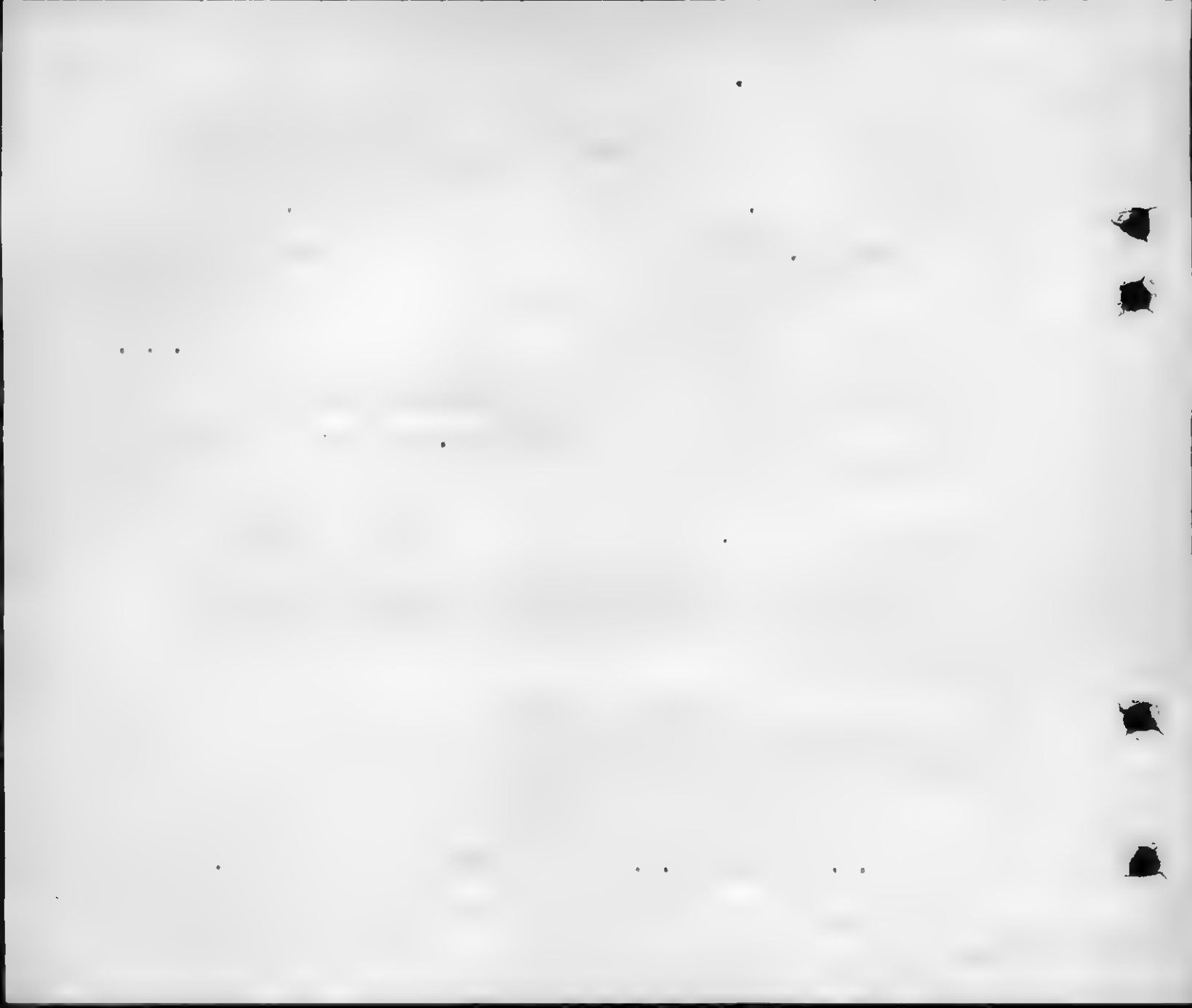
VR A15 (4)
ISM 9/59

8931

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08923

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe	
c. LENGTH OF STAY IN 1b 5 yrs.		d. STREET ADDRESS /1243 Francis Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1243 Francis Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabel V. Tubbs		4. DATE OF DEATH Month August Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/77
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Roland F. Tubbs		Address 1243 Francis Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Chronic renal insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Don't know (c) Don't know		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intermittent cardiac arrhythmia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 12, 1957 to August 6, 1961 , that (I) (we) last saw the deceased alive on July 12, 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. J. Donovan		22b. DATE SIGNED August 6, 1961	
22c. PHYSICIAN'S NAME (Type) R. J. Donovan M.D.		22d. ADDRESS 732 Charing Cross Rd. (29)	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/61	
23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City, town, or county) (State) Anna Arundelle, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Sp. Rd.		25. REC'D BY REGISTRAR DATE AUG 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician or attending physician be the one who signs the certificate. The law also requires that the attending physician or attending physician be the one who signs the certificate. The law also requires that the attending physician or attending physician be the one who signs the certificate.

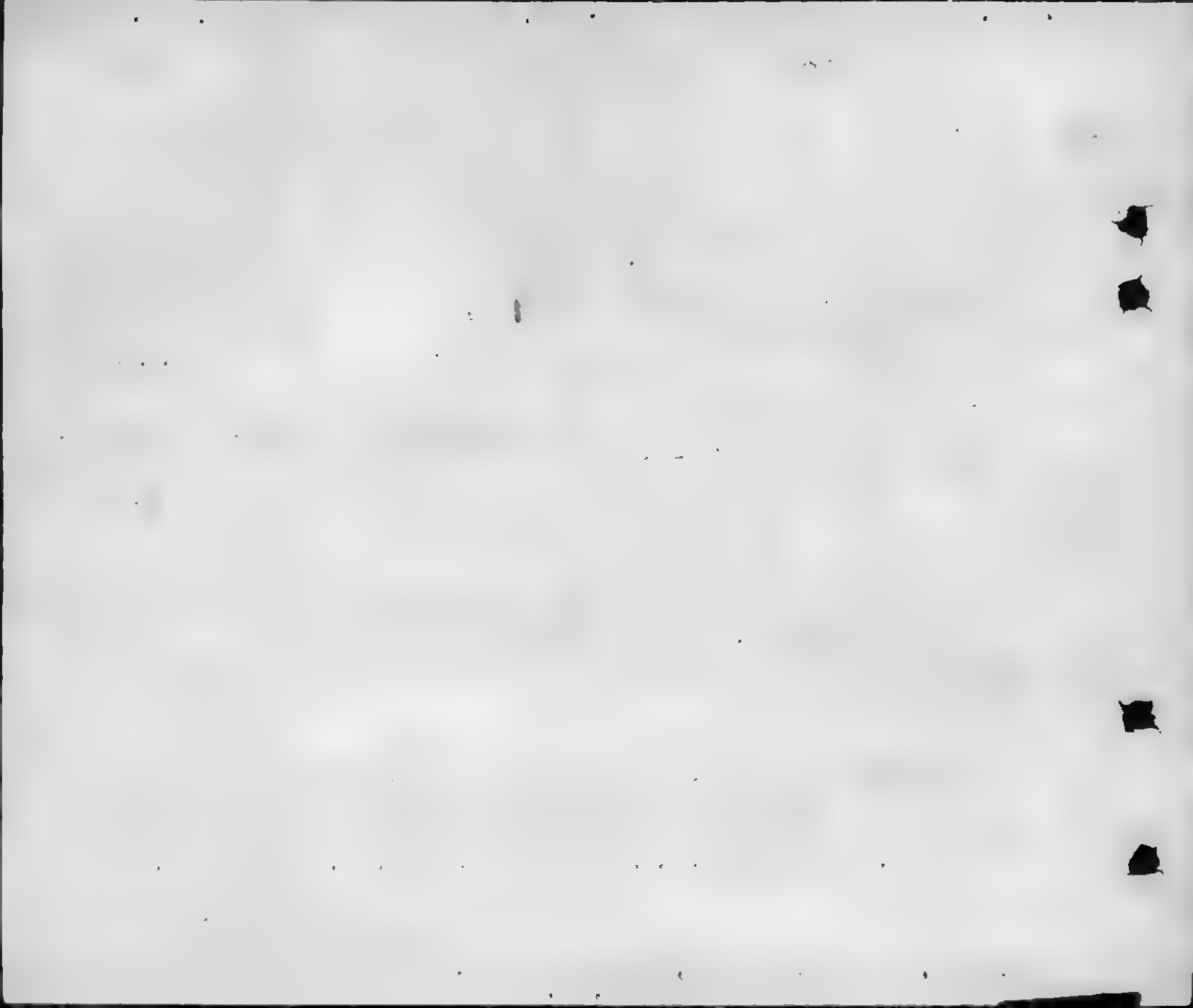
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8932

08924

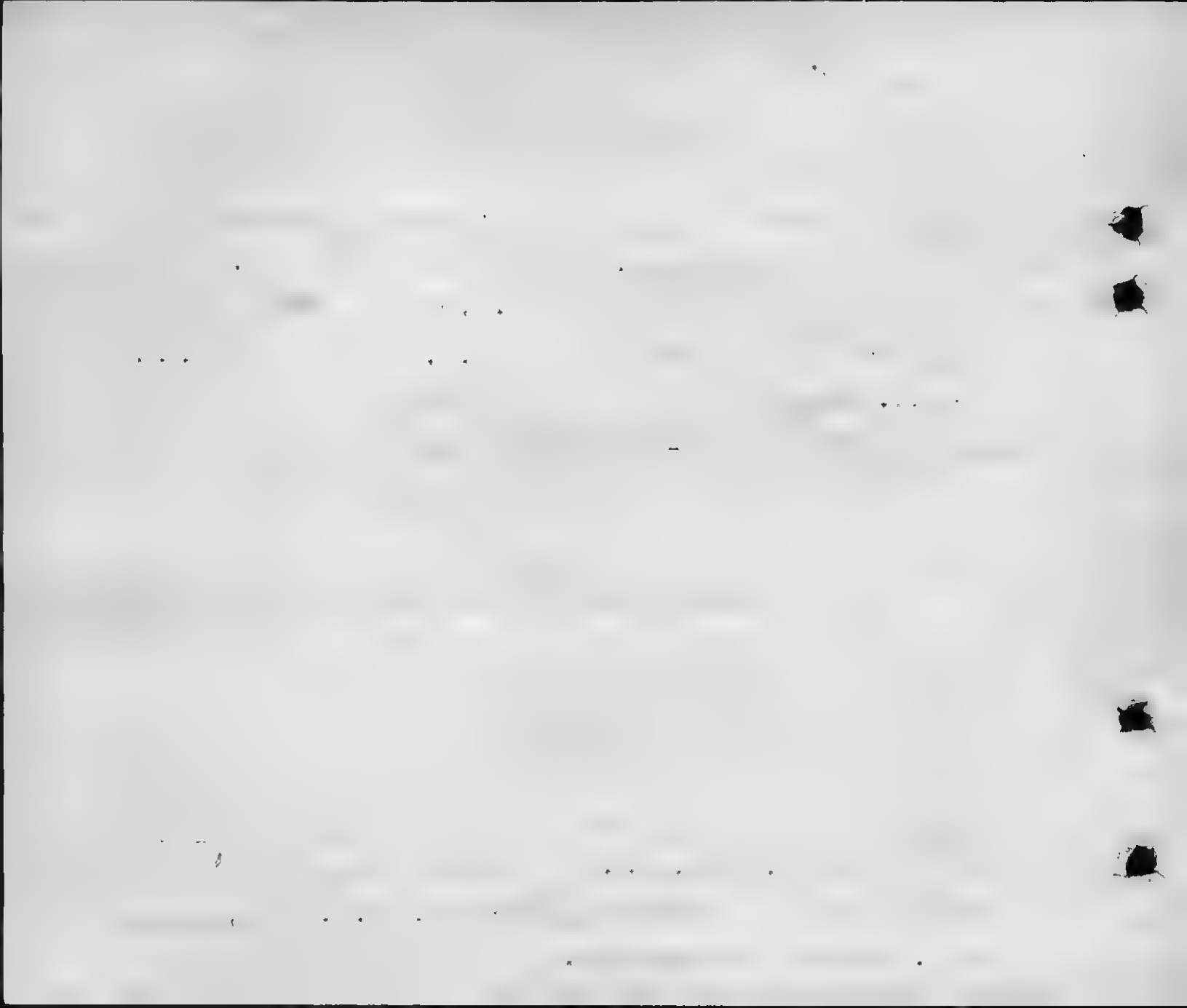
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY (in days) 227 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 608 BURGUNDY STREET d. STREET ADDRESS 608 BURGUNDY STREET	
3. NAME OF DECEASED (Type or print) ARTHUR E. TWYMAN		4. DATE OF DEATH Month Day Year AUGUST 26 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Worker		10b. KIND OF BUSINESS OR INDUSTRY Market	9. AGE (in years last birthday) 46 yrs.
13. FATHER'S NAME John Twyman		14. MOTHER'S MAIDEN NAME Bertha Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) Yes WW II		16. SOCIAL SECURITY NO. 236-03-1008	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE FROM GI TRACT DUE TO ESOPHAGEAL VARICES DUE TO FATTY LIVER WITH CIRRHOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY CONGESTION.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. WAS ALTOUPSY PERFORMED? YES		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 10, 1961 , to August 26, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 26, 1961 and that death occurred at 12:00N from the causes and on the date stated above.			
22a. SIGNATURE Lawrence Rubin		22b. DATE SIGNED 8/26/61	
22c. PHYSICIAN'S NAME (Type) H. LAWRENCE RUBIN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV.	
23b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. DATE THEREOF 8-31-61		23e. LOCATION (City, town or county) (State) BALTIMORE 28, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR AUG 30 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Francis			

Elroy O. Wilson Funeral Home, 1000 Brantley Ave.
Balto. Md.



V5. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21 (Essex)		c. LENGTH OF STAY in 1b 581 Edgewater Apartments		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Essex) 21	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 581 Edgewater Apartments		4. DATE OF DEATH Last Aug. 24 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Male		14. MOTHER'S MAIDEN NAME Lillian Sykes		4. DATE OF DEATH Month Aug.	
5. SEX Male		16. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) N. C.	
13. FATHER'S NAME John L. Underwood		14. MOTHER'S MAIDEN NAME Lillian Sykes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) Yes WW1		16. SOCIAL SECURITY NO. 246-24-7644		17. INFORMANT Ellen Underwood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcohol and paraldehyde intoxication 888.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested paraldehyde in addition to alcohol.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown 8/24 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Baltimore 21		20g. (County) Balto.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-24-61	
ACTUAL SIGNATURE Russell S. Fisher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/61		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial Pk.	
22d. LOCATION (City, town, or country) A. A. County, Maryland		22e. REC'D BY REGISTRAR AUG 28 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Hanes	
23. FUNERAL DIRECTOR James E. Bruzdinski 1407 Eastern Ave.		ADDRESS			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8934

08926

(M)

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
b. COUNTY

Md.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore 27

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

House In The Pines, 16 Fusting Ave

d. STREET ADDRESS

4427 Allen Drive

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Jeanette

Valentine

4. DATE OF DEATH

Month

Day

Year

Aug.

18,

19 61

5. SEX

F.

6. COLOR OR RACE

W.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

April 2, 1885

9. AGE (in years last birthday)

76 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H.W.

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Peel

14. MOTHER'S MAIDEN NAME

Anne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name)

Address

Mrs. Lawrence W. Pruitt,

1934

Old Frederick Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Myocardial Infarction

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Hypertensive Cordis-Vascular Disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 hr.

10 min.?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

20d. INJURY OCCURED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 8-16, 1961, to 8-18, 1961, that (I) (two) last saw the deceased alive on 8-18, 1961, and that death occurred at 6:00 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Wilmer K. Gallager

Wilmer K. Gallager M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

8-18-61

22d. ADDRESS

6209 Frederick Ave. Balt. 28 Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF

REMOVAL (Specify)

Burial Aug. 21, 61

23c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Pk. Balto. Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Witzke F.D. 4101 Edmondson Ave

25a. REC'D BY REGISTRAR

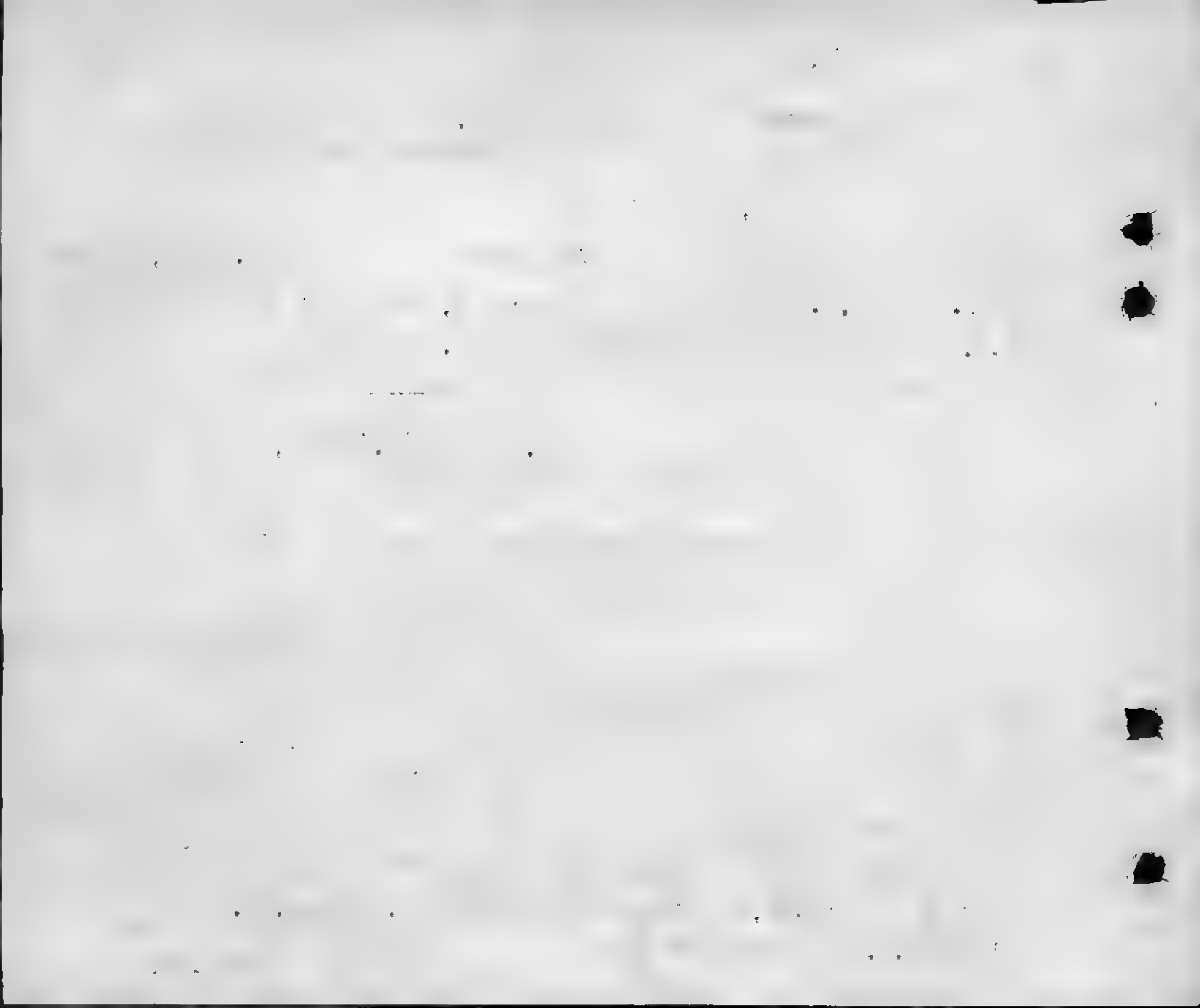
25b. REGISTRAR'S SIGNATURE

DATE AUG 21 '61

Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8935

CERTIFICATE OF DEATH

08927

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 d. STREET ADDRESS 427 South Macon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE S. VARIPATIS		4. DATE OF DEATH August 29 19 61	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH November 15, 1915 9. AGE (In years last birthday) 45 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 11. BIRTHPLACE (County & State, or foreign country) Weirton W. Virginia 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Estratius J. Varipatis 14. MOTHER'S MAIDEN NAME Irene De Foni 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 213-07-3066 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) (a) BRONCHOGENIC CARCINOMA, RIGHT BRONCHUS WITH METASTASIS TO LEFT LOWER LOBE (b) SEVERE CHRONIC NEPHROSCLEROSIS (c) MYOCARDIAL HYPERTROPHY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from August 27 1961 , to August 29 1961 , that (X) (we) last saw the deceased alive on August 29 1961 , and that death occurred at PM , from the causes and on the date stated above. 22a. SIGNATURE SEBASTIAN RUSSO, M. D. 22b. DATE SIGNED 8/30/61 22c. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-2-61 23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery 23d. LOCATION (City, town or county) (State) Baltimore County, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Matthews Funeral Home 25a. REC'D BY REGISTRAR SEP 5 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MEDICAL CERTIFICATION

TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

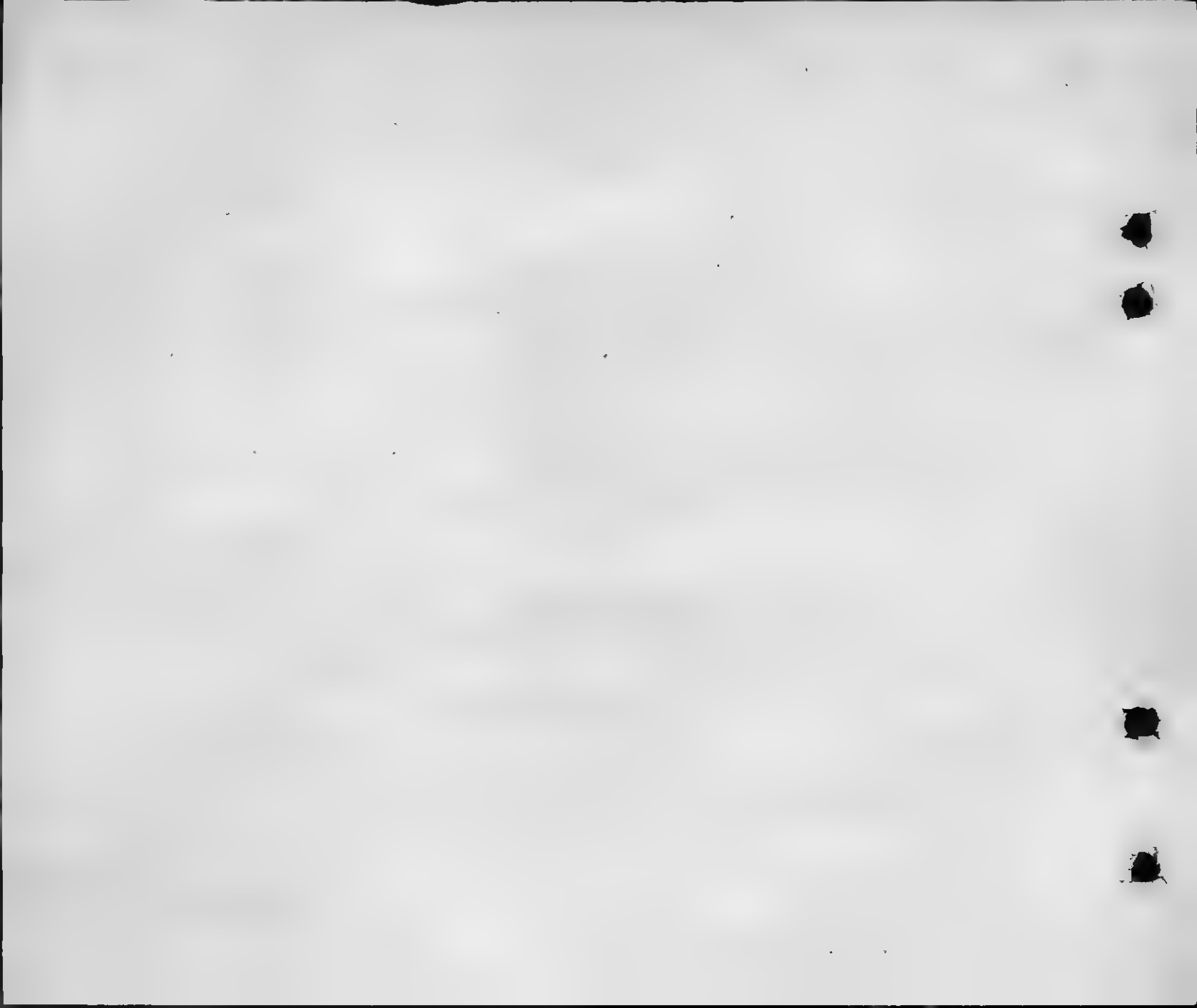


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician must complete and fill in by the funeral director. This certificate has been signed by the attending physician and complete. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
Baltimore				Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
Rogers Forge				Baltimore			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
609 Murdock Road, Zone 12				609 Murdock Rd.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
JOHN H. VOLZ				August 2 19 61			
5. SEX				6. COLOR OR RACE			
male				white			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				10/18/1881			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
Maintenance				Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph A. Volz				Sophia Hodes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
				213-05-1055			
17. INFORMANT				Address			
Sophia Volz, daughter, above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				2 yts.			
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
Pulmonary Emphysema, Severe				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 1959 to Aug 1961, that (I) (we) last saw the deceased alive on July 25, 1961, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Wm H. Kammer, Jr.				3 Aug. 1961			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
Wm H. Kammer, Jr.				6011 York Rd. Balto. 12, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				8/5/61			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Baltimore Cemetery				Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Charles E. Schimunek Funeral Home				DATE AUG 4 '61			
3331 Brehms Lane				25b. REGISTRAR'S SIGNATURE			
				William E. Schimunek			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

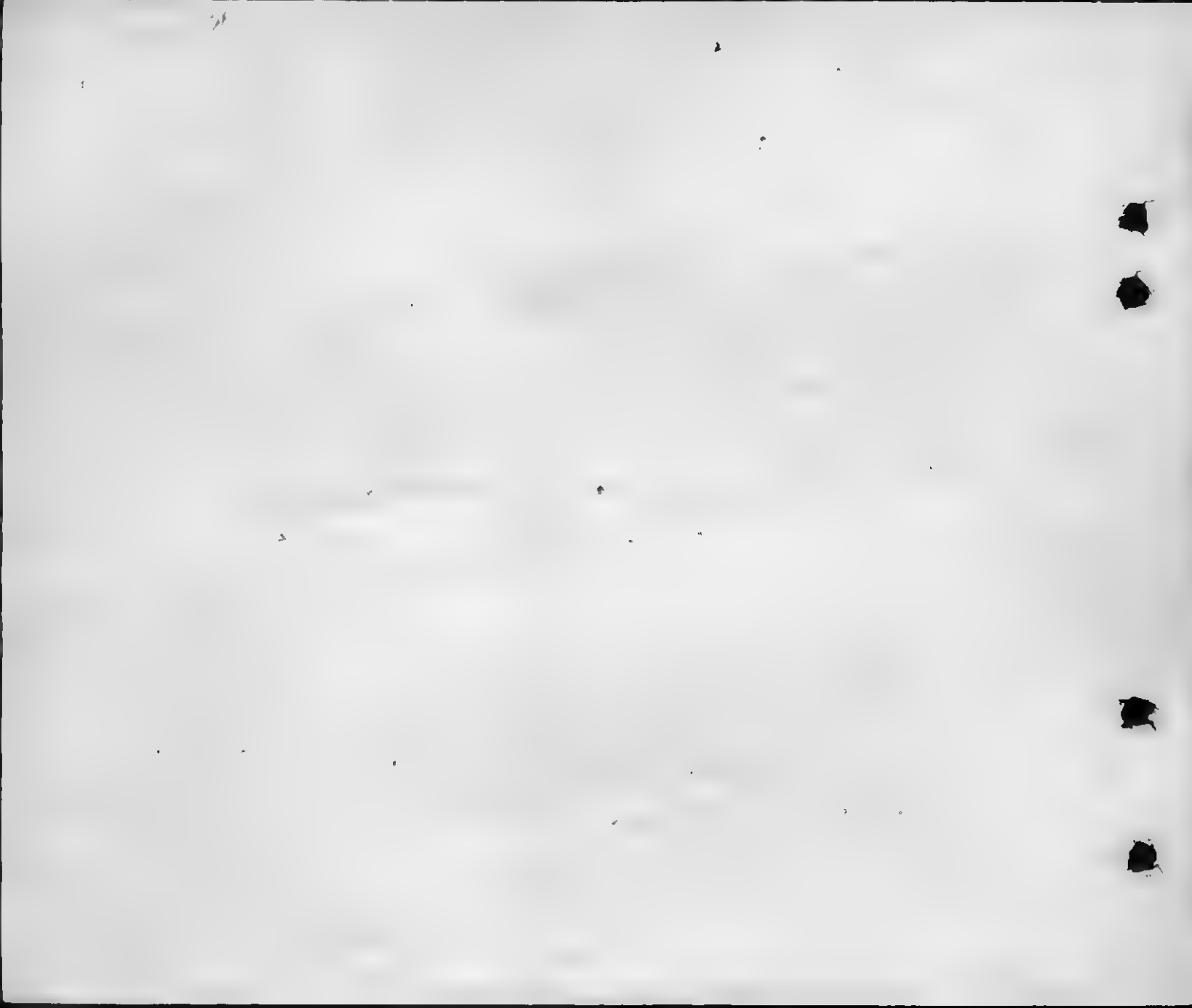
CERTIFICATE OF DEATH

8937

08929

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1913 LISMORE AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1913 LISMORE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) <u>MILTON PARKER VORE</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>24</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 7, 1914</u>		9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>6</u> IF UNDER 24 HRS.: Hours <u>8</u> Min. <u>+</u>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ELEC. CO.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>CALIFORNIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>MILTON P. VORE, JR.</u>						14. MOTHER'S MAIDEN NAME <u>JOSEPHINE WOOD</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO <u>NO</u>						17. INFORMANT Address <u>Mrs. Milton P. Vore - 1913 Lismore Ave</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Acute myelogenous leukemia</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>8 mo +</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)														20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>8/24</u> , 19 <u>61</u> , to <u>8/24</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on... <u>8/24</u> , 19 <u>61</u> , and that death occurred at... <u>8P</u> M., from the causes and on the date stated above.														22a. SIGNATURE <u>James E. Rorer</u>		22b. DATE SIGNED <u>8/25/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>James E. Rorer</u>						22d. ADDRESS M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-28-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem</u>				23d. LOCATION (City, town or county) <u>Balto Md.</u>													
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stacy - Cavanaugh & F.H. Catonsville, Md.</u>														25a. REC'D BY REGISTRAR DATE <u>SEP 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the attending physician complete, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. It is to be completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8938

CERTIFICATE OF DEATH

Item 7 Film 8938 8/15/61

08950

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b. 125yr7mth6dys		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodsboro, Maryland d. STREET ADDRESS 1002		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First		Middle		Last		4. DATE OF DEATH Aug 7 1961	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Sept. 8, 1876		9. AGE (in years last birthday) 84 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		12. SOCIAL SECURITY NO unknown		13. INFORMANT Records: SPRING GROVE STATE HOSPITAL		14. BIRTHPLACE (County & State, or foreign country) Maryland		15. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. FATHER'S NAME Thomas Jefferson Weinbrenner		17. MOTHER'S MAIDEN NAME unknown		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral and Generalized arteriosclerosis (c) 1 week PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 week		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)		25. I certify that (if hospital) attended the deceased from Dec. 25 to Aug. 7 , that (I) (we) last saw the deceased alive on Aug. 7 , 19 61 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.	
26. SIGNATURE Stella Wachslar M.D.		27. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		28. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		29. REC'D BY REGISTRAR Aug 11 '61		30. REGISTRAR'S SIGNATURE William S. Kinne	
31. BURIAL, CREMATION, REMOVAL (Specify) Burial		32. DATE THEREOF 8/10/1961		33. NAME OF CEMETERY OR CREMATORY Hope		34. LOCATION (City, town or county) (State) Woodsboro		35. FUNERAL DIRECTOR'S SIGNATURE W.C. Barton	



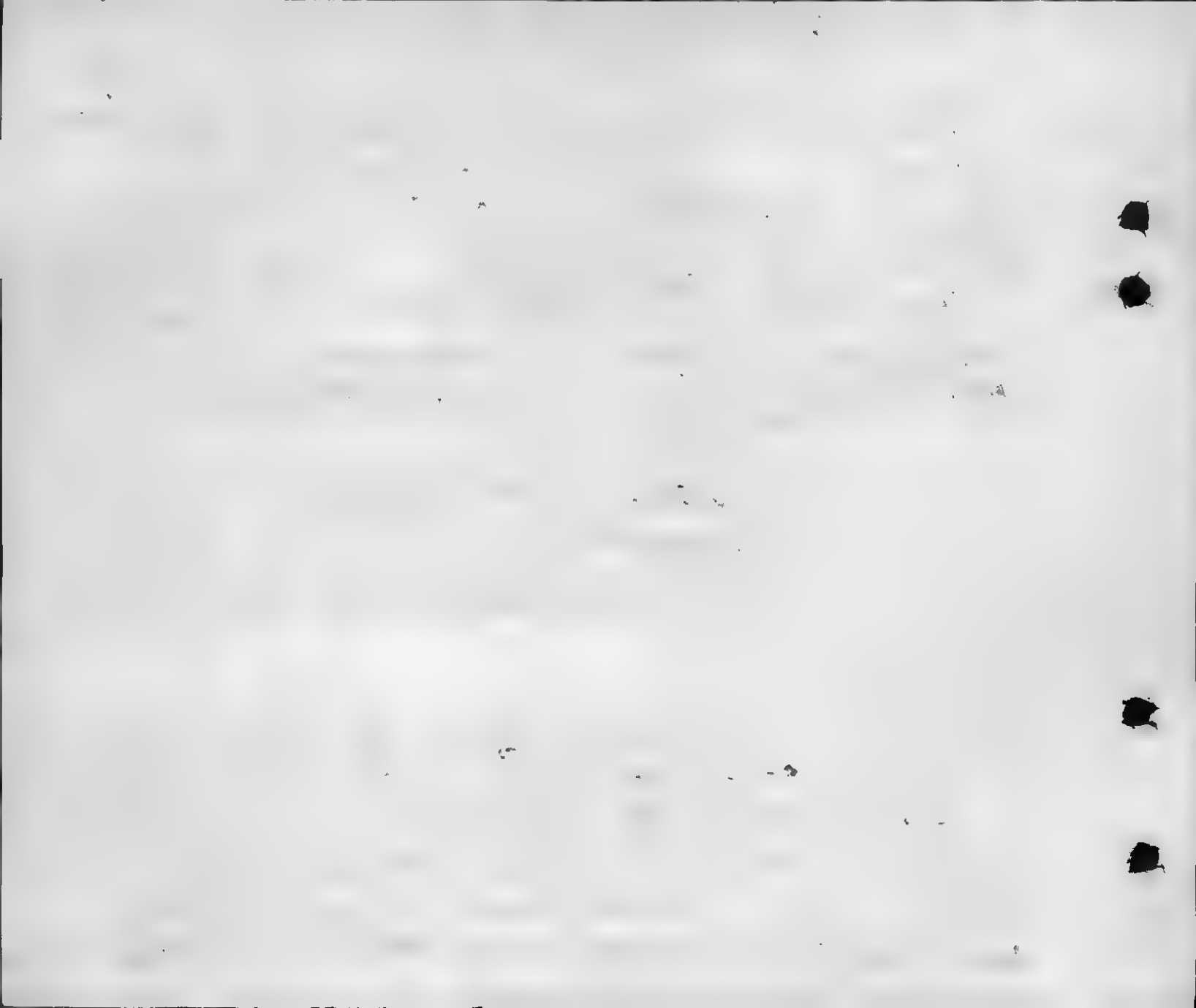
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3940
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08932

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>		c. LENGTH OF STAY IN 1b <u>PARKTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MT CARMEL & EUNA RDS.</u>		d. STREET ADDRESS <u>1 MT. CARMEL & EUNA RDS.</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE VALIANT WEST</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		13b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
14. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		15. CITIZEN OF WHAT COUNTRY? <u> </u>	
16. FATHER'S NAME <u>HERB JOSEPH G. VALIANT</u>		17. MOTHER'S MAIDEN NAME <u>ELIZA ANN OLIVER</u>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		19. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u> </u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio - Sclerotic Cardio Vascular disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO <u> </u> (a), stating the underlying cause last, (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>61</u> to <u>8-13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-13</u> , 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Herbert Mueller Jr</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-15-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN D. MITCHELL & SONS, INC.</u>		25a. REC'D BY REGISTRAR <u>AUG 16 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knepp</u>		25c. ADDRESS <u>1900 EUTAW PLACE</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

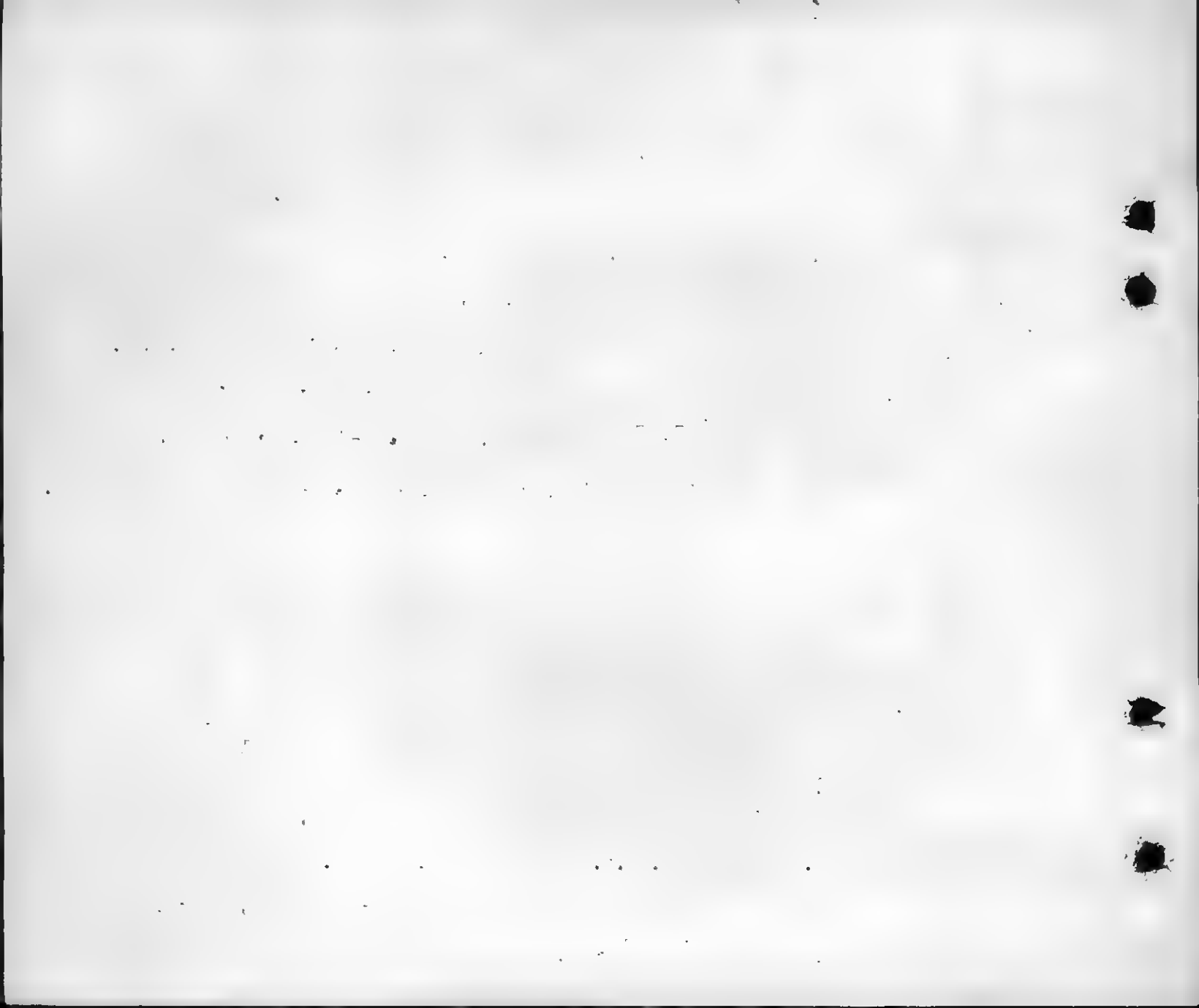
CERTIFICATE OF DEATH

Reg. Dist. No. 18903

8041

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3716 Mohawk Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle B. Last West		4. DATE OF DEATH Month August Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1893
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months 6 Days 10	11. IF UNDER 24 HRS Hours 10 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl August Boucsein		14. MOTHER'S MAIDEN NAME Louise Caroline Bersch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-34-0100	
17. INFORMANT Joan W. Gundlach-2411 Poplar Dr. #7		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) *****		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) *****	
20c. TIME OF INJURY Month, Day, Year Hour ***** 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> *****	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) *****	
21. I certify that I attended the deceased from 19 55 to August 61 , that I last saw the deceased alive on August 21, 19 61 , and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Ave. DATE SIGNED 8/22/61			
ACTUAL SIGNATURE <i>Millard T. Traband, Jr.</i>		M.D. 5101 Gwynn Oak Ave.	
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M.D.		Baltimore, 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/25/61	22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR AUG 22 '61	24b. REGISTRAR'S SIGNATURE <i>Robert S. Kline</i>
Ellsworth Armacost 4600 Liberty Heights Ave.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

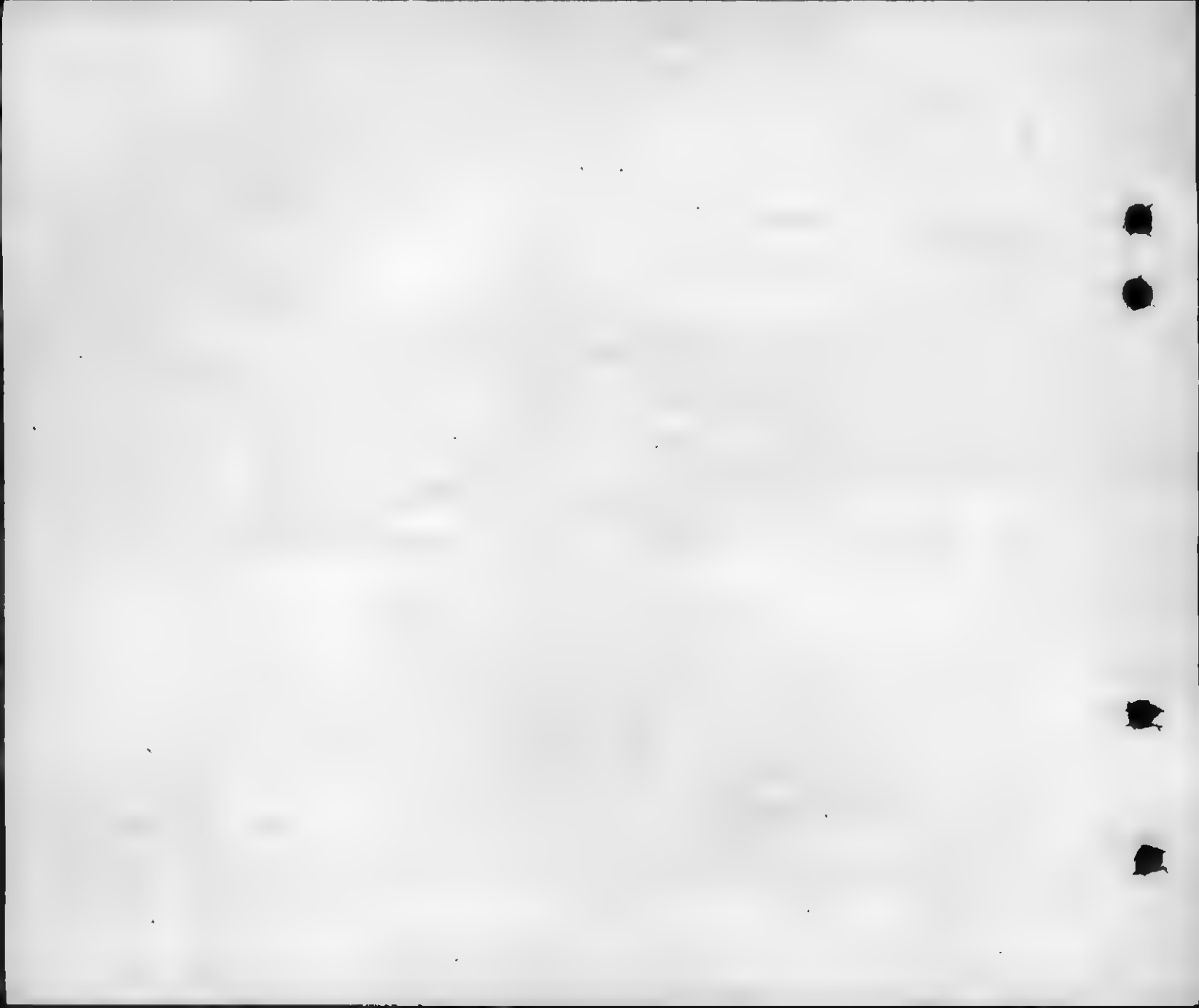
8942

CERTIFICATE OF DEATH

Reg. Dist. No. 08984

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	
c. LENGTH OF STAY IN 1b 9 years		d. STREET ADDRESS Dunmanway Extended	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dunmanway Extended		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PERRY ALBERT WILBURN, Jr.		4. DATE OF DEATH Month Day Year August 3rd, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1942
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry A. Wilburn, Sr.		14. MOTHER'S MAIDEN NAME Ida Oehring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 219-40-2189	
17. INFORMANT P. A. Wilburn, Sr., same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO (b) Convulsion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Ep. lepsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-1 , 19 55 , to 8-3 , 19 61 , that I last saw the deceased alive on 7-10 , 19 61 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Jack Collins M.D. 2 Kinsship 8-3-61 PHYSICIAN'S NAME (Type) JACK C COLLINS Baltimore 22 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/5/61	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial	22d. LOCATION (City, town, or county) (State) Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Brooks Bradley, Inc., Dundalk 22, Md		24a. REC'D BY REGISTRAR DATE AUG 7 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus





15
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8944 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08936

1. PLACE OF DEATH
a. COUNTY **BALTIMORE** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **RURAL - COCKEYSVILLE**
c. LENGTH OF STAY IN 1b **HARRISBURG EXPRESSWAY**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE **MD** b. COUNTY **—**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **BALTIMORE CITY**
d. STREET ADDRESS **5316 THE ALAMEDA**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **WILMER JEANNE WOLF**
4. DATE OF DEATH **AUG. 5 1961**
5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **4-21-13** 9. AGE (In years) **48** (If UNDER 1 YEAR, Months Days; If UNDER 24 HRS., Hours Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CLAIMS ADJUSTER U.S. GOVT.** 10b. KIND OF BUSINESS OR INDUSTRY **U.S. GOVT.** 11. BIRTHPLACE (State or foreign country) **PENNA.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **WARREN A. WOLF** 14. MOTHER'S MAIDEN NAME **LOLA ARNOLD**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **YES WWII** 16. SOCIAL SECURITY NO. **—** 17. INFORMANT **RITA I. WOLF** Address **ABOVE**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **MYOCARDIAL INFARCTION** DUE TO **420.1**
Conditions, if any, which gave rise to immediate cause (b) **—**
(c), stating the underlying cause last. DUE TO **—**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **—**

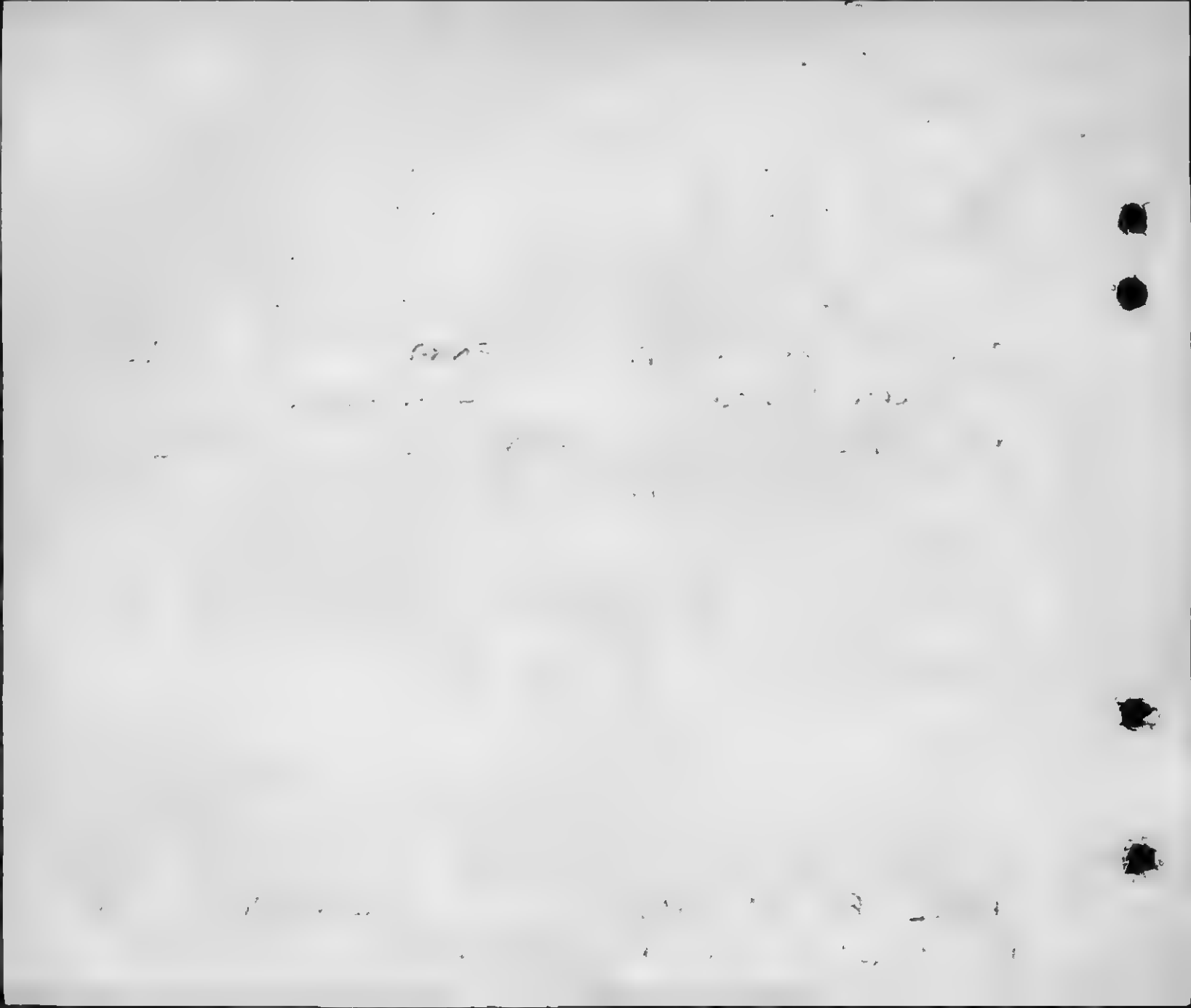
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ INTERVAL BETWEEN ONSET AND DEATH **3 MIN.**

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) **—**
20c. TIME OF INJURY Month, Day, Year **—** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **—** 20f. (City or town) (County) (State) **—**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER **—**
ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **8-5-61**
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) **—**

ACTUAL SIGNATURE **William A. Pillsbury** M.D.
EXAMINER'S NAME (Type) **WILLIAM A. PILLSBURY**
22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **8-9-61** 22c. NAME OF CEMETERY OR CREMATORY **GRANDVIEW** 22d. LOCATION (City, town, or county) (State) **ALLENTOWN PA.**

23. FUNERAL DIRECTOR **H.W. JENKINS & SONS Co. 4905 YORK RD. BALTO. 12** ADDRESS **—** 24a. REC'D BY REGISTRAR **—** 24b. REGISTRAR'S SIGNATURE **—** DATE **AUG 9 '61**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

2045

118907

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X PIKESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1703 REISTERSTOWN RD		d. STREET ADDRESS 1703 REISTERSTOWN RD	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MAE YOUNG		4. DATE OF DEATH Month Day Year AUGUST 30 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 2, 1906
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPATCHER		10b. KIND OF BUSINESS OR INDUSTRY HUMANE SOCIETY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME WILLIAM MORRIS		14. MOTHER'S MAIDEN NAME ELIZABETH MEASLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 218A-92-9887	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Embolic - Pulmonary DUE TO 60X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dissecting Aortic Aneurysm - 1st Left Ventricle (c) Coronary Heart Failure - Chronic		INTERVAL BETWEEN ONSET AND DEATH. Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1954 to August 30, 1961 , that I last saw the deceased alive on August 28, 1961 , and that death occurred at 2:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. McWilliam		ADDRESS (Street, city or town, state) M.D. 11904 Reisterstown Rd, Reisterstown, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED Aug 30, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 3, 1961	
22c. NAME OF CEMETERY OR CREMATORY SATERS BAPTIST CEM.		22d. LOCATION (City, town, or county) (State) LUTHERVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burrows, Son, Towson, Md.		24a. REC'D BY REGISTRAR DATE SEP 5 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kravitz			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

B.P.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8946

Item 14 Film G293 8/24/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

08938

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rosedale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rosedale			
c. LENGTH OF STAY IN lb 7 yrs.				d. STREET ADDRESS 11235 PRIMROSE AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1235 PRIMROSE AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA BARBARA ZARAS.				4. DATE OF DEATH Month Day Year August 18 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1887	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Anton Cernohorsky				14. MOTHER'S MAIDEN NAME Rosalie Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT Address Anna R. West 1235 Primrose Ave. Balto.-G.Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic - Hypertensive C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal Carcinoma							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1961 to Aug 18, 1961 , that I last saw the deceased alive on Aug 18, 1961 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8019 Philadelphia Rd., Baltimore, Maryland DATE SIGNED 8/18/61							
ACTUAL SIGNATURE John G. Orth, M.D.				PHYSICIAN'S NAME (Type) John G. Orth, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 21, 1961		22c. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cwach				ADDRESS 1211 Chesaco Ave. Balto.-G.Md.		24a. REC'D BY REGISTRAR DATE Aug 21 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8947
CERTIFICATE OF DEATH

08939

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 17 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 26 d. STREET ADDRESS 7819 Bridge Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL J. L. ZELLER		4. DATE OF DEATH Month Day Year August 30 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1894 9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Munitions Inspector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George J. Zeller		14. MOTHER'S MAIDEN NAME Emily Scheckels	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 106-10-10000	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO ACUTE NEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) 5910X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) August 13 1961, August 30 1961, that (u) (we) last saw the deceased alive on August 30 1961, and that death occurred at 1:20 P.M. from the causes and on the date stated above.
21. I certify that (this hospital) attended the deceased from August 13 1961, to August 30 1961, that (u) (we) last saw the deceased alive on August 30 1961, and that death occurred at 1:20 P.M. from the causes and on the date stated above.		22a. SIGNATURE SEBASTIAN RUSSO, M.D. 22b. DATE SIGNED 8/30/61	
22c. PHYSICIAN'S NAME SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-2-61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Anne Arundel County, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully, 237 Patapsco Ave., Balto. Md.		25a. REC'D BY REGISTRAR SEP 1 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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Medical Officer

Medical Officer

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Veterans Administration Hospital

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